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THE MEDICAL SERVICES INSURANCE ENQUIRY

Proceedings of the Public Hearings
held at the Galbraith Building,
University of Toronto,
Toronto, Ontario, at 10:00 a.m.
on Wednesday, December 11th, 1963.

1964

VOLUME

DATE

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VERBATIM REPORTING SERVICE
OFFICIAL REPORTERS
TORONTO, ONTARIO

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Miss Anne-Marie Giffey
Mrs. George Berton

THE CANADIAN MENTAL HEALTH ASSOCIATION

Appearances: Mrs. G.C.V. Hewson
Dr. Paul Christie
Mr. Donald Sinclair

THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO and
THE ONTARIO DENTAL ASSOCIATION

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THE CHRISTIAN SCIENCE CHURCH

Appearances: Leslie A. Tutts

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Mr. CARMAN A. MAYLOR

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1 --- On commencing at PROVINCE OF ONTARIO

2 MEDICAL SERVICES INSURANCE ENQUIRY

3 come to order, please? I take it that the ladies in front of
4 me here are the Proceedings of the Public from the St. Eliz-
5 beth Visiting Nurse Association, Ontario, Hearings held at the
6 Galbraith Building, Ontario, University of Toronto,
7 Toronto, Ontario, at 10:00
8 a.m. on Wednesday, December
9 11th, 1963. SUBMISSION ELIZABETH VISITING NURSES'

10 MEMBERS OF ENQUIRY: ASSOCIATION OF ONTARIO

11 Dr. J. GERALD HAGEY -- Chairman

12 Miss Anne-Marie Quigley

13 Mrs. J.A. AYLEN -- George Berthon

14 Dr. WILLIAM BUTT I would like to read to you the

15 instructions Miss HELEN CARPENTER delegations appearing before

16 the Enquiry. Mr. DALTON J. CASWELL

17 Mr. A. ROY COULTER Enquiry have received and

18 studied the Dr. R.J. GALLOWAY. In accordance with the guide

19 for participants Dr. JOHN HAMILTON that was mailed to you, it will

20 not be necessary Mr. W.S. MAJOR read your brief, but you do have

21 an opportunity Miss HELEN McARTHUR large upon its conclusions or

22 recommendations Mr. P.J. MULROONEY

23 Mr. CARMAN A. NAYLOR Enquiry may ask you questions on

24 the statement Mr. HARRY SIMON one submitted in your brief, but

25 you are not Mr. J.L. WHITNEY examination or cross-examination

26 by other persons Mr. L.E. TURNER -- Secretary

27 It is not our intention to debate your sugges-

28 tions or recommendations, nor ----- the views of this



PROVINCE OF ONTARIO

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Mrs. J.A. AYLEN

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Miss HELEN CARPENTER

Mr. DALTON J. CASWELL

Mr. A. ROY COULTER

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Mr. HARRY SIMON

Mr. J.L. WHITNEY

-- Secretary

Mr. L.E. TURNER

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1 --- On commencing at 10:00 a.m. any opinions expressed in ques-
2 tions asked or THE CHAIRMAN: Ladies and gentlemen, will you
3 come to order, please? I take it that the ladies in front of
4 me here are the members of the delegation from the St. Eliza-
5 beth Visiting Nurses' Association of Ontario. ~~man feels that~~
6 ~~another member is better qualified to answer a specific ques-~~
7 SUBMISSION OF THE ST. ELIZABETH VISITING NURSES'
8 ASSOCIATION OF ONTARIO ~~er member to answer.~~

9 Appearances: Mrs. Thomas Enright ~~okesman; and~~
10 Miss Anne-Marie Quigley
11 Mrs. George Berthon

12 THE CHAIRMAN: I would like to read to you the
13 instructions that I read to all delegations appearing before
14 the Enquiry. ~~hem to the members of the press at the conclusion~~
15 of your submis Members of the Enquiry have received and
16 studied the brief you submitted. In accordance with the guide
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20 recommendations. ~~or of the St. Elizabeth Visiting Nurses' Asso-~~

21 ciation. Members of the Enquiry may ask you questions on
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23 you are not to be subjected to examination or cross-examination
24 by other persons. ~~on behalf of the St. Elizabeth Visiting~~
25 ~~Nurses' Assoc~~ It is not our intention to debate your sugges-
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SUBMISSION OF THE ST. ELIZABETH VISITING NURSES'

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1 Enquiry on them. Consequently, any opinions expressed in ques-
2 tions asked or statements made by members of the Enquiry are
3 intended for clarification only. commendations contained in
4 our submission. As stated in the instructions, one person is to
5 act as your spokesman. However, if the spokesman feels that
6 another member is better qualified to answer a specific ques-
7 tion from a member of the Enquiry, the spokesman may receive
8 the Chair's permission to request the other member to answer.
9 people of Metro. Will you please identify your spokesman, and
10 then proceed. quest service, regardless of their creed. All
11 patients must. The members of the press have requested a copy
12 of your brief, and if you have copies with you, perhaps you
13 will hand them to the members of the press at the conclusion of
14 of your submission.

15 MISS QUIGLEY: I am Anne-Marie Quigley, Dr. point
16 Hagey. that there has been an increase in the older-age population

17 THE CHAIRMAN: Miss Quigley? chronic diseases

18 MISS QUIGLEY: Miss Quigley, yes. I am the
19 Executive Director of the St. Elizabeth Visiting Nurses' Asso-
20 ciation. d in the acute stages, these patients respond more

21 favourably to THE CHAIRMAN: Will you proceed then, please?

22 MISS QUIGLEY: Mr. Chairman and members of the
23 Enquiry, speaking on behalf of the St. Elizabeth Visiting
24 Nurses' Association and in particular for the members of our
25 Association present with me today, Mrs. George Berthon, our



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15 MISS QUIGLEY: I am Anne-Marie Quigley, Dr.

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17 THE CHAIRMAN: Miss Quigley?

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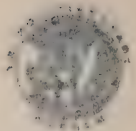
1 President, on my right, and Mrs. Enright, our District Super-
2 visor, on my left, I would like to briefly review the work of
3 this Association and also the Recommendations contained in
4 our submission to this Enquiry.

5 The St. Elizabeth Visiting Nurses' Association
6 was founded in 1908 and granted a charter by the Province of
7 Ontario in November, 1916. This Association provides profes-
8 sional nursing care on a visiting basis, to the Catholic
9 people of Metro Toronto and Toronto Township as well as all
10 others who request service, regardless of their creed. All
11 patients must be under medical supervision of a physician or
12 hospital clinic. A maximum fee is charged whenever possible
13 but this fee may be adjusted according to the patients' ability
14 to pay.

15 In dealing with our recommendations may I point
16 out that there has been an increase in the older-age population
17 and an accompanying rise in the incidence of chronic diseases
18 which can be cared for at home.

19 In many instances if a program of rehabilitation
20 is applied in the acute stages, these patients respond more
21 favourably to treatment; the progress of the illness is
22 deterred and the overall cost to the community is lessened.

23 In addition to this, the older person improves
24 more rapidly in a familiar environment provided adequate care
25 is available through a Visiting Nurse program. However,



1 President, on my right, and Mrs. Wright, our District Agent.
2 Vice, on my left, I would like to briefly review the work of
3 this Association and also the recommendations contained in
4 our submission to this Inquiry.

5 The St. Elizabeth's Hospital, which was
6 was founded in 1882 and granted a charter by the Province of
7 Ontario in November, 1946. This association provides
8 almost entirely care on a voluntary basis, to the patients
9 people of Metro Toronto and Toronto Township as well as all
10 others who request service, regardless of their creed. All
11 patients must be under medical supervision of a physician or
12 hospital official. A maximum fee is charged where possible
13 but this fee is adjusted according to the patient's ability
14 to pay.

15 In dealing with our recommendations may I point
16 out that there has been an increase in the short-term hospital
17 and an accompanying rise in the incidence of chronic diseases
18 which can be cared for at home.

19 In many instances it is a program of rehabilitation
20 required in the acute stages, from which patients respond more
21 favorably to treatment. The program of the illness is
22 delayed and the overall cost to the community is lessened.
23 In addition to this, the older person improves
24 more rapidly in a familiar environment provided adequate care
25 is available through a visiting nurse program. However,



1 payment for this care is often an added financial burden beyond
2 the family's economic abilities.

3 We wish to request that should the proposed Act
4 respecting Medical Services Insurance be implemented, that
5 some consideration be given to the role of the Visiting Nurse
6 and how she might supplement the work of the Medical Practi-
7 tioner.

8 The nurse working directly under the supervision
9 of a private physician or hospital clinic visits on a regular
10 basis to perform the necessary treatments. The family then is
11 instructed to care for the patient in her absence. The visits
12 are determined as the need indicates; the frequency and dura-
13 tion dependent entirely on the condition of the patient. We
14 go in to patients as the condition indicates. This may be once
15 a week or it may be twice a week. It may be on a daily basis.
16 In other words, we are a visiting service. We go in and do
17 whatever is to be done and then leave.

18 In recent years with changing medical practices
19 toward shorter period of hospitalization, greater demands for
20 short-term but more intensive care is being requested from
21 Visiting Nurse Agencies.

22 In lieu of this, the comprehensive care of the
23 patient should make full use of all auxiliary services inclu-
24 ding those of visiting nurses.

25 To make this more acceptable, the public must be



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To make this more acceptable, the public must be



1 made aware that public health nursing is socially and medically
2 acceptable to all income levels.

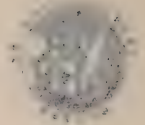
3 We feel that public health nursing is an integral
4 part of total patient care as it is based on the philosophy of
5 prevention of disease, promotion of health, and restoration of
6 the patient to his maximum capacity, and will find its best
7 utilization when recognized as such by the community, the
8 hospital, the physicians and professional workers.

9 Mr. Chairman, if we may answer questions, Mrs.
10 Enright on my left, and Mrs. Berthon on my right, would be
11 very pleased to do so.

12 THE CHAIRMAN: Thank you. Some of the members of
13 the Enquiry have indicated a desire to ask some questions.
14 Miss McArthur?

15 MISS McARTHUR: Thank you, Mr. Chairman. Miss
16 Quigley, if I interpret what you said correctly, you are indi-
17 cating that visiting nursing is an essential part of an overall
18 medical insurance plan, if such can be conceived some time in
19 the future, such as not presently outlined in Bill 163, and I
20 wondered if you were asking and indicating that there was an
21 area in which greater co-operation, more effective utilization,
22 and so on, might be thought through, even though it is not
23 under the Bill at this time? Is this what you have in mind?

24 MISS QUIGLEY: Yes. We feel that - and this is
25 from actual experience - that there are many instances where a



acceptable to all income levels.

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Mr. Chairman, if we may answer questions, Mrs. Enright on my left, and Mrs. Berthon on my right, would be very pleased to do so.

THE CHAIRMAN: Thank you. Some of the members of the Board have indicated a desire to ask some questions.

MISS McARTHUR: Thank you, Mr. Chairman. Miss O'Grady, if I interpret what you said correctly, you are indicating that visiting nursing is an essential part of an overall medical insurance plan, if such can be conceived some time in the future, such as not presently outlined in Bill 163, and I wondered if you were asking and indicating that there was an area in which greater co-operation, more effective utilization, and so on, might be thought through, even though it is not under the Bill at this time? Is this what you have in mind?

MISS O'GRADY: Yes. We feel that - and this is from actual experience - that there are many instances where a



1 nurse is requested to go into a home and I would like to stress,
2 first of all, that a nurse, as you know only too well, always
3 goes in under the direct supervision of the attending physician
4 and gives whatever nursing care the doctor prescribes. We feel
5 that there are many cases where a patient will benefit by the
6 services of nurses going in, but that the patient is not in a
7 position to pay for those services.

8 Now, to be a little more specific - and this is
9 actual experience - where patients have some type of coverage,
10 but the one type of coverage that does not seem to be included
11 is for the visiting nurse to go in. A nurse on a full-time
12 basis, yes; but not for the visiting nurse to go in. And so
13 often we are going to go in to give care because the patient
14 cannot go to the doctor's office or it is not convenient for
15 them to do so and the doctor has requested that we, as nurses,
16 go in and, under his direction, give a piece of service and we
17 feel that in lieu of this there should be some consideration
18 for the nurse going to the home.

19 First of all, she is saving the doctor time and
20 also, very often, he does not wish to go, simply because we
21 can do the work and we feel that we should be recognized, as I
22 say, supplementing the work of the physician.

23 MISS McARTHUR: I notice on page 8 of your
24 brief, on your home care program, you say that since July 1st,
25 1961, when the program was extended, you have only had such a



first of all, that a nurse, as you know only too well, always goes in under the direct supervision of the attending physician and gives whatever nursing care the doctor prescribes. We feel that there are many cases where a patient will benefit by the services of nurses going in, but that the patient is not in a position to pay for those services.

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First of all, she is saving the doctor time and also, very often, he does not wish to go, simply because we can do the work and we feel that we should be recognized, as I say, supplementing the work of the physician.

MISS McARTHUR: I notice on page 8 of your brief, on your home care program, you say that since July 1st, 1961, when the program was extended, you have only had such a



1 referral in one instance. Only once?

2 MISS QUIGLEY: Yes.

3 MISS McARTHUR: Is this only a question of
4 proportion in terms of the service rendered, or do you think
5 there are other reasons for that?

6 MISS QUIGLEY: When the pilot program was first
7 instigated, we were very active in that; however, as it was
8 expanded, thinking in terms of this newer program, patients
9 being discharged from hospital, we have, as I say, only had
10 the one case and this was a patient who was under referral
11 before they went into the hospital and it was automatically
12 referred back to us.

13 Now, perhaps, if I might, Mrs. Enright is in a
14 better position to speak of this, being the District Supervisor,
15 but this was my experience with this home care program.

16 MRS. ENRIGHT: I have very little to add to what
17 Miss Quigley said; these patients that are coming into the new
18 home care program are hand-chosen, plus the fact that they
19 requested this. Now, why we have not had the referrals, I do
20 not know.

21 MISS McARTHUR: I was wondering if the delega-
22 tion felt that their service, if it could not be within the
23 present proposals, whether they saw visiting nursing as an
24 additional benefit that might be offered by private carriers.
25 In other words, can you see it operating effectively if it were



1 referral in one instance. Only once?

2 MISS GUILLEY: Yes.

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21 MISS McARTHUR: I was wondering if the delaga-

22 tion felt that their service, if it could not be within the
23 present proposals, whether they saw visiting nursing as an
24 additional benefit that might be offered by private carriers.
25 In other words, can you see it operating effectively in its



1 offered as a benefit under the insurance now that some of the
2 facets are being cared for by Bill 163?

3 MISS QUIGLEY: I think that we like to be very
4 realistic and I think that being in the homes the way we are,
5 being in such a variety of homes, very often over a long period
6 of time, we come to know our patients very well and one thing
7 that has been said to us on more than one occasion - for
8 instance, I am thinking of a patient who is covered for
9 hospital. They say, "I have this coverage as long as I am in
10 the hospital, but when I come home I do not have it, and I
11 can't pay you. I can see it is being carried over into this
12 insurance plan, too. I have coverage for my doctor, but my
13 doctor can't come to me. You are giving me a service, but I
14 can't pay you."

15 We are supplementing the work of the doctor.
16 We can't go in unless the doctor prescribes. So we are his
17 messenger, if you will. We are doing what he wants done,
18 whether he does it or whether we do it.

19 MISS McARTHUR: I just have one more question.
20 How do you control the mis-use, or how would you propose you
21 might control this if it was included in an insurance plan?

22 MISS QUIGLEY: We are very firm in our own
23 administration, primarily as to allotment of cases. We have
24 only so many nurses and we feel that it is the need of the
25 patient which indicates the service. We decide, along with the



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1 patient and, of course, the doctor - for instance, we decide
2 whether a patient needs daily care. I am thinking of a dres-
3 sing. We will go in once or twice a week and get the patient
4 to the stage where he will only need care once a week. Whether
5 it is under an insurance plan or whether it is an indigent
6 patient, it does not matter; we have the same philosophy. It
7 is the need of the patient, and as that improves, then we
8 decrease the care.

9 When the visiting nurse is in a home, she gives
10 care to her patient but she also instructs someone to give care in her
11 absence, so that as her patient does progress, we feel that our
12 visits are less frequent.

13 THE CHAIRMAN: Miss McArthur, can you define
14 what you suggested by mis-use? Do you mean the service being
15 used when it is not necessary?

16 MISS McARTHUR: Yes. I was thinking of a comment
17 that I heard somewhere along the way, that some nurses - and
18 I have the feeling this was in relation to private practice -
19 were doing housekeeping instead of nursing.

20 MISS QUIGLEY: Yes. I must say that when we
21 go into patients, sometimes they expect us to do this type of
22 thing, or they will even say, "Can you come and stay all day?"
23 I mean, this is an interpretation of services; but we decree
24 the amount of services given to the patient, with the doctor's
25 sanction, and, certainly, taking the patient's care into

patient and, of course, the doctor - for instance, we decide whether a patient needs daily care. I am thinking of a dressing. We will go in once or twice a week and get the patient to the stage where he will only need care once a week. Whether

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THE CHAIRMAN: Miss McArthur, can you define what you suggested by mis-use? Do you mean the service being used when it is not necessary?

MISS McARTHUR: Yes. I was thinking of a command that I heard somewhere along the way, that some nurses - and I have the feeling this was in relation to private practice -

MISS GUILLY: Yes. I must say that when we



1 consideration, but as they progress, we withdraw. It is the
2 need, irrespective of what the patient is paying.

3 THE CHAIRMAN: Dr. Butt?

4 DR. BUTT: On page 2 of your summary, you say
5 your cost per visit is \$4 and then later you say that your
6 actual cost is higher than this; is this correct?

7 MISS QUIGLEY: Our actual cost for 1962 was
8 \$4.17. Now, this is computed by our auditor at the end of the
9 year when he comes in to complete our financial statement.
10 Now, it is the philosophy of visiting nursing that you try to
11 keep your fee to cover the cost. Our cost per visit in 1960
12 was \$3.98 and we did increase it then to \$4. So, it is not
13 good practice to change it every year.

14 DR. BUTT: But this is a statistical cost?

15 MISS QUIGLEY: Yes, this is a statistical cost.
16 This might change this year. This cost is computed at the end
17 of the current year.

18 DR. BUTT: You mention that 5.7% of your
19 patients are able to pay the full fee.

20 MISS QUIGLEY: Yes.

21 DR. BUTT: That does not mean to say that that
22 is all that pay fees?

23 MISS QUIGLEY: No; full fees, on a maximum cost
24 of \$4 a visit.

25 DR. BUTT: Can you give me the percentage of



consideration, but as they progress, we withdraw. It is the
need, irrespective of what the patient is paying.

THE CHAIRMAN: (to Dr. Butt)

DR. BUTT: On page 2 of your summary, you say

your cost per visit is \$4 and then later you say that your

actual cost is higher than this; is this correct?

MISS GUILLEY: Our actual cost for 1962 was

\$4.17. Now, this is computed by our auditor at the end of the

year when he comes in to complete our financial statement.

Now, it is the philosophy of visiting nursing that you try to

keep your fee to cover the cost. Our cost per visit in 1960

was \$3.98 and we did increase it then to \$4.20, it is not

good practice to change it every year.

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of \$4 a visit.

DR. BUTT: Can you give me the percentage of



1 your revenue which comes from fees?

2 MISS QUIGLEY: Nursing fees, 13.22%. This is
3 on page 15.

4 DR. BUTT: So that the fees really do not make
5 a great contribution to your order?

6 MISS QUIGLEY: No. They are a very small part.
7 As you can see, we are a United Community Fund agency.

8 DR. BUTT: Do groups such as the Cancer Society
9 supply dressings and things like that?

10 MISS QUIGLEY: Yes.

11 DR. BUTT: This is one other source, then?

12 MISS QUIGLEY: Yes.

13 DR. BUTT: Now, coming to your day care...

14 MISS QUIGLEY: If I might, Mr. Chairman, Mrs.
15 Enright had a comment there on the Cancer Society.

16 MRS. ENRIGHT: With regards to community organi-
17 zations, they help the organization. It supplies a very small
18 amount of any kind of relief help, as far as dressings or equip-
19 ment.

20 DR. BUTT: So they do help you, apart from your
21 cash output?

22 MISS QUIGLEY: They do not make any cash contri-
23 bution.

24 DR. BUTT: No. But they help in supplies?

25 MISS QUIGLEY: The Cancer Society actually works

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2 dressings. But we will either refer the patient to the Cancer
3 Society or, if it is a new patient, the Cancer Society will
4 refer the patient to a visiting nursing agency and will pay for
5 the first visit for the visiting nurse to come in and interpret
6 the service of the Cancer Society to the patient - I mean what
7 is available to her as her illness progresses, and then working
8 together with the various community resources, the Cancer
9 Society being one of them.

10 DR. BUTT: In your home care under the O.H.S.C.,
11 you have only had one case in which this home care pilot
12 program has been utilized; is that correct?

13 MISS QUIGLEY: Yes.

14 DR. BUTT: Would you be happy if that were
15 extended?

16 MISS QUIGLEY: Yes.

17 DR. BUTT: This sort of thing you would like?

18 MISS QUIGLEY: Yes. I think perhaps it is just
19 the mechanics of referrals, really. We are a well-qualified
20 agency. Of our 22 staff, 17 are public health nurses.

21 DR. BUTT: Do you know where these groups go;
22 what nursing organization they utilize?

23 MISS QUIGLEY: The pilot...?

24 DR. BUTT: Up till now - the O.H.S.C.?

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20 agency. Of our 25 staff, 17 are public health nurses.
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22 what nursing organization they utilize?
23 MISS QUIGLEY: The pilot...?
24 MR. BUTT: Up till now - the O.H.S.C.?



1 organization is the Victorian Order of Nurses. There are just
2 the two of us.

3 DR. BUTT: Is there much of an overlapping
4 between the work that you people are doing and the public
5 health, the City of Toronto public health nurses? As I under-
6 stand it, they do a certain number of the same thing that you
7 are speaking about.

8 MISS QUIGLEY: First of all, I think I can
9 safely say that health agencies in general - this is something
10 that health agencies are very proud of. We have very little
11 overlapping because we work very closely together. Now, the
12 official health department, which is the City of Toronto,
13 their work is geared to prevention through education. They
14 go to schools and child health centres. Theirs is all preven-
15 tion education, not because they are not qualified, but
16 because their scope would be too large. So they, in turn,
17 would refer patients that require visiting nurses to us, or to
18 a visiting nurses' agency.

19 Now, we work very closely. Both visiting
20 nurses' agencies and health departments work very closely
21 together and one way that we do prevent overlapping is that we
22 have what we call the notification of services. So, if we go
23 in to a patient, we notify the health department and when our
24 little green slips go through they know we are on the case.

25 So, by the same token, if they are in visiting

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1 a mother during her pre-natal period and they realize that the
2 other visiting nurses' agency is already in the home, perhaps
3 giving a nursing service, they will notify us and they will
4 withdraw and we would also carry on whatever service they
5 were giving. So, we do prevent overlapping and our services
6 are very different.

3 7 DR. BUTT: Are they not overlapping, like your
8 group teaching and your child health clinics?

9 MISS QUIGLEY: No.. This is a very small part -
10 25%, approximately - and where we would be doing this group
11 teaching, as well as well-baby care, is patients that have
12 been referred to us for some other reason.

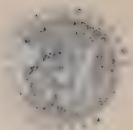
13 DR. BUTT: But does not the public health group
14 of nurses conduct those clinics?

15 MISS QUIGLEY: Are you thinking of child health
16 centres?

17 DR. BUTT: Yes. Whatever names they put on them,
18 Well-baby clinic is noted here.

19 MISS QUIGLEY: Yes.. They purchase our services.
20 They purchase our services. I was thinking of visiting in the
21 home. They also do pre-natal teaching in the home on an indivi-
22 dual basis. They purchase our services on an hourly basis,
23 recognizing that we are a public health agency and we have
24 public health personnel available to supplement their staff.

25 THE CHAIRMAN: Mr. Mulrooney?



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THE CHAIRMAN: Mr. Mulrooney?



1 MR. MULROONEY: I think all the questions I
2 had have been answered, thank you.

3 THE CHAIRMAN: Mr. Caswell?

4 MR. CASWELL: You place considerable emphasis
5 on the fact that there seems to be greater need for education
6 of the public and even of the Medical Association as to the
7 availability of public health nursing and the value of it to
8 the public and to the medical members. Whose responsibility do
9 you feel this public relations is? Are you suggesting that
10 it should be part of this medical act services to more
11 greatly publicize the fact that this service is available?

12 MISS QUIGLEY: I think the very fact that this
13 type of service is available, or would be available through a
14 medical insurance plan, in itself, gives strength, gives sanc-
15 tion, if you will. It is acknowledging that this type of
16 program, a visiting nurses' program, is recognized, is acknow-
17 ledged, and is accepted, and the very fact that it would be
18 available under a plan, it would have the effect on the public,
19 on the doctors, on everyone - it would act as a reminder that
20 this service is available to them.

21 MR. CASWELL: I think that this service is a
22 most commendable one, not just yours, but all public health
23 nursing service provided by community groups such as yours.
24 If this came under, in any way or, in effect, Bill 163, the
25 community who, to a degree, was taken out of this service

MR. MULLOONY: I think all the questions I

had have been answered. Thank you.

THE CHAIRMAN: Mr. Caswell?

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this service is available to them.

MR. CASWELL: I think that this service is a

very important one, and that it is one of the most

valuable services that we have.

It has come under, in any way or, in effect, Bill 163, the

community who, to a degree, was taken out of this service



1 which has been given, do you feel this is good to have the
2 community interests divorced from humanity's? Generally, it is
3 expressed that it is part of our responsibility as one person
4 to our brother to take an interest in his welfare. If this
5 were all paid for under any medical plan, hospitalization plan
6 or otherwise, very quickly that community interest would die?

7 MISS QUIGLEY: I think I can say to that, and
8 I would like to go back to an earlier statement of mine, that
9 the care is indicated by the need of the patient. So, if I
10 understand your question correctly, it does not really matter.
11 This is quite apart from the care of your patient. In other
12 words, whether the patient can provide means to pay for her
13 services or whether they fall in the category of an indigent
14 patient or whether they are a free patient, if nursing care is
15 required, they receive the care. To carry this a little
16 further, when a nurse goes into a home for a new patient,
17 quite often the fee, if there is to be one, is not set till the
18 second or third visit.

19 But, by the same token, we have to exist and
20 our services, too, have to be paid for if we are going to be
21 able to maintain an adequate nursing service.

22 MR. CASWELL: But at the moment, is this not
23 controlled, the need, to a large degree, by the economic situa-
24 tion? The number of public health nurses that you have avail-
25 able are limited for the great demand. If this was all paid



1 for, then would your public health nursing service not expand
2 to the degree that you would not have to be as careful about
3 whether you went to a patient once a week or three times a
4 week? In other words, if the money is available to expand
5 your service, you could then come to the point where you were
6 calling on this patient every day?

7 THE CHAIRMAN: I think that is a question that
8 is almost impossible to answer.

9 MR. CASWELL: It certainly has considerable
10 bearing on whether consideration should be given.

11 MISS QUIGLEY: I do not think we will ever have
12 a sufficient number of nurses where we could ever be that
13 extravagant.

14 THE CHAIRMAN: Dr. Galloway?

15 DR. GALLOWAY: My questions are very brief.

16 Miss Quigley has almost brought forward one of the questions
17 and I noted that you have some 20 nurses at the moment. What
18 problems do you have in recruitment of nurses at the present
19 time, if you did wish to expand?

20 MISS QUIGLEY: I think the problem is the same
21 with any agency, and that is available staff. Now, actually,
22 we are quite fortunate with staff. We have a certain turnover
23 of staff, which I think any agency experiences, but on the
24 whole we are fairly fortunate with the staff that we are able
25 to get. Mind you, we have a strict criteria. Preference is

for, then would your public health nursing service not expand

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we are quite fortunate with staff. We have a certain turnover

Mind you, we have a strict criteria. Preference is



1 given to public health nurses. Right now we are full staffed.

2 DR. GALLOWAY: The one patient that you did
3 have through this pilot scheme; how were you paid and who paid
4 you?

5 MISS QUIGLEY: May I turn this over to Mrs.
6 Enright?

7 MRS. ENRIGHT: We send a bill for services
8 directly to the pilot care program and I presume, in turn,
9 they would bill the Hospital Commission, but our cheque was
10 returned, or our payment was returned to the pilot program.

11 DR. GALLOWAY: This is primarily subsidized by
12 the Ontario Hospital Services Commission?

13 MRS. ENRIGHT: Yes.

14 DR. GALLOWAY: Do you receive any payment from
15 any of the insuring companies on extended health benefits?

16 MRS. ENRIGHT: No.

17 DR. GALLOWAY: There are some plans that do
18 offer nursing services; are these directly in hospital?

19 MISS QUIGLEY: Yes. We have run into this.
20 In fact, we have had some rather specific experiences in this.
21 The criteria seems to be, first of all, that the patient must
22 first be admitted to hospital and then, on discharge, there are
23 very few plans that will actually cover visiting nursing.
24 This seems to be one criteria. We have had one specific
25 experience and this particular patient was cared for at home,



1 I have a letter of introduction from the Vernon District Service, dated
2 1908, and have been admitted to the hospital, and
3 though visiting nursing was covered in her particular plan,
4 we were not eligible because she had not been admitted.
5 From time to time, we will have patients who
6 will send in their insurance forms to us to sign for our
7 services and sometimes they have sent them in to the company,
8 but in almost every instance they are returned because
9 visiting nursing is not covered. Full-time nurses, yes.
10 DR. GALLOWAY: You stated that you render your
11 service in Metropolitan Toronto. This is a provincial medical
12 health insurance plan that is going into effect. Who services
13 Hamilton and the outlying districts and Suburby and every other
14 place?
15 MISS QUICKLEY: The Victorian Order of Nurses
16 are across Canada. We are in the City of Toronto, Metropolitan
17 Toronto, and Toronto Township. There is another St. Elizabeth
18 Visiting Nurses in Hamilton. It was this original organization
19 for Metropolitan Toronto and there is visiting nurses' services
20 in some places.
21 DR. GALLOWAY: These are primarily public health
22 MISS QUICKLEY: No. Victorian Order of Nurses
23 is national.
24 We were founded in 1908 here at that time to
25 provide for the general population and to give nursing



1 over a period of four weeks, but because she had had a coronary
2 and she had not been first admitted to the hospital, even
3 though visiting nursing was covered in her particular plan,
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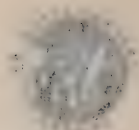
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2 our experience that we do not overlap. We work closely
3 together. It is, perhaps, one great pride of health agencies.
4 We feel that we have rather set the pattern of showing other
5 agencies how to prevent overlapping.

6 We have worked very closely together. This is
7 not a problem. We are really a Catholic agency but we feel
8 that we can give service to all and we give service to anyone
9 who requests it.

10 DR. GALLOWAY: In your brief, you seem to stress
11 the fact that what you are doing is giving home service which,
12 most frequently, is supplementing post-hospital care of
13 patients. This morning you were speaking more of supplementing
14 the physician's services. On which aspect of this do you think
15 that you should be included in the plan more strongly?

16 MISS QUIGLEY: This is why it is our feeling
17 that we should be included in the plan, because when I said
18 post-hospital care, the fact remains that we are still going
19 in to give service under a physician. Whether it be the
20 packing of a dressing or whatever it is, the physician has
21 prescribed the treatment. This is the basis of our being in
22 the home.

23 So, in other words, we are going to give the
24 treatment in lieu of the physician going himself and this is
25 why we feel that consideration should be given to visiting



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1 nursing because, as I say, we are supplementing the work of
2 the physician. Theoretically, if we do not go, he would have
3 to; just in theory only, but this is what it amounts to.

4 THE CHAIRMAN: Mr. Simon?

5 MR. SIMON: Do you feel that if all nursing
6 service were included under Bill 163 there are enough nurses
7 in the province to cover this kind of a service?

8 MISS QUIGLEY: Speaking for our own agency, I
9 would feel yes, because I think that there would be an over-
10 lapping of patients. There are many patients that we would be
11 giving service to.

12 THE CHAIRMAN: I think the question is asked
13 not specifically for your own organization.

14 MISS QUIGLEY: No. I think you are giving a
15 service to these patients across the province, whether they
16 are covered by a plan or not. But there would be enough
17 nurses because the nurses quite often are going in, anyhow.
18 This is the thing.

19 MR. SIMON: According to your own assumption,
20 there would be less visits by the physician and more of it
21 would be based on the responsibility of the visiting nurses?

22 MISS QUIGLEY: Yes.

23 MR. SIMON: And I agree with you. My question
24 is: do you feel there are enough nurses? I read so much about
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1 MISS QUIGLEY: I feel there would be, and I
2 think the point that Mrs. Enright is trying to make, and which
3 I am trying to make is that we feel in many cases we would be
4 called upon to go in anyhow, so we would have to spread our
5 service. We would have to try and meet this need, whether it
6 was covered or not. But I think we would have enough nurses.

7 MR. SIMON: You stated that if the services
8 are rendered under the direction of a doctor - are there cases
9 where the nurse would recommend a doctor and is that always
10 available to indigent patients?

11 MISS QUIGLEY: That the nurse would recommend a
12 doctor?

13 MR. SIMON: Yes.

14 MISS QUIGLEY: We have a policy that the
15 patient must be under care. Now, we will go in and make one
16 visit to a patient who is not directly under the care of a
17 physician but we really assess the situation and then we
18 would tell them that they would have to call a doctor and we
19 cannot return unless they were under a doctor. Very often, if
20 it is a case where a patient has a family physician that they
21 haven't seen for years, they will contact him or we will for
22 the patient; but we must have his permission and he must know
23 the patient and he must prescribe the patient.

24 MR. SIMON: Thank you.

25 THE CHAIRMAN: Mr. Naylor?

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MR. SIMON: Thank you.

THE CHAIRMAN: Mr. Naylor?



1 MR. NAYLOR: The question I am going to ask
2 refers to a point raised by Dr. Galloway with regard to bene-
3 fits paid for nursing service under major medical plans. I
4 believe that the major medical plans and extended care plans
5 issued by the insurance companies now, and which presumably
6 will still be issued as supplementary coverage if this plan is
7 put into effect, pay benefits for care by registered nurses,
8 regardless of whether they are on a full-time basis or a
9 visiting basis. They do not go beyond that to care by practi-
10 cal nurses or nursing assistants because of the problem of
11 distinguishing between what is really a necessary nursing
12 care and what is housekeeping duties.

13 This is true of my own company and I know of
14 other plans I have seen. I wanted to ask what proportion of
15 the care provided by your service is given by registered
16 nurses and what part by other types?

17 MISS QUIGLEY: On our staff of 22, we have
18 three registered nursing assistants; so that in that propor-
19 tion the best part of the care is given by registered nurses.
20 Now, the patient that is being given care by a registered
21 nursing assistant is a chronically ill patient who takes a
22 fair bit of time but doesn't require the services of a skilled
23 nurse.

24 Now, I am speaking of a registered nurse. How-
25 ever, we have a policy that every fifth visit must be made by



MR. MAYLOR: The question I am going to ask refers to a point raised by Dr. Galloway with regard to benefits paid for nursing service under major medical plans. I believe that the major medical plans and extended care plans issued by the insurance companies now, and which presumably will still be issued as supplementary coverage if this plan is put into effect, pay benefits for care by registered nurses,

regardless of whether they are on a full-time basis or a visiting basis. They do not go beyond that to care by practical nurses or nursing assistants because of the problem of distinguishing between what is really a necessary nursing care and what is housekeeping duties.

This is true of my own company and I know of other plans I have seen. I wanted to ask what proportion of the care provided by your service is given by registered nurses and what part by other types?

MISS QUIGLEY: On our staff of 25, we have three registered nursing assistants; so that in that proportion the best part of the care is given by registered nurses.

Now, the patient that is being given care by a registered nursing assistant is a chronically ill patient who takes a fair bit of time but doesn't require the services of a skilled

nurse.

Now, I am speaking of a registered nurse. However, we have a policy that every fifth visit must be made by



1 a registered nurse. This, mind you, is our own agency policy
2 and it is to give a type of supervision to the patient.

3 MR. NAYLOR: I do not understand the first part
4 of your answer. Is it more than 50% of the visits by a
5 registered nurse?

6 MISS QUIGLEY: It is a very small proportion,
7 really; less than 1%. It is the long-term illness, the
8 chronically ill patient that the nurse goes in and bathes and
9 gets them up, and this type of thing. It is a very small
10 percentage.

11 MR. NAYLOR: A small percentage is by registered
12 nurses?

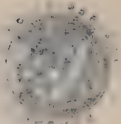
13 MISS QUIGLEY: Registered nursing assistants,
14 which is a practical nurse.

15 MR. NAYLOR: In other words, a large proportion
16 then is by registered nurses?

17 MISS QUIGLEY: Yes.

18 MR. NAYLOR: I believe that if claims for these
19 expenses were submitted under any major medical plan, in most
20 cases they would be paid. I know there is no condition that
21 they must have been in hospital.

22 MISS QUIGLEY: We have had this experience quite
23 recently. Mrs. Enright has had personal experience. In
24 visiting nursing, what the practical nurse can do is very
25 limited. For instance, in visiting nurses the practical nurse



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MISS QUIGLEY: We have had this experience with

recently. Mrs. Knight has had personal experience. In

visiting nursing, what the practical nurse can do is very

limited. For instance, in visiting nurses the practical nurse



1 does nothing but go in and give care to a patient, which
2 consists of giving him a bath and looking after him. They are
3 not allowed to give any kind of injections or irrigations.
4 The scope is limited. It is only about 1% that is done by
5 the registered nursing assistant.

6 THE CHAIRMAN: Mr. Coulter?

7 MR. COULTER: I am interested mainly in the
8 areas outside metropolitan areas and I understand that your
9 Association is mainly in a couple of metropolitan areas; in
10 Hamilton and Toronto?

11 MISS QUIGLEY: Our Association is, yes.

12 MR. COULTER: I believe you said a while ago
13 that you thought there were enough nurses probably to cover
14 the entire province if this were expanded in Bill 163 to
15 cover your services. This part I am a little worried about.
16 I have a daughter in the profession and I know a little about
17 the nursing profession. If it were expanded to cover all of
18 the rural areas and Northern Ontario, and so forth, wouldn't
19 there be considerable conflict with the public health nurses
20 and the Victorian Order of Nurses, or can you speak for these
21 particular people as well?

22 MISS QUIGLEY: I cannot speak specifically for
23 the group. In our brief, we continually refer to "visiting
24 nurses' programs," and there are only two - the Victorian
25 Order and ours. I can safely say that our policies are almost



consists of giving him a bath and looking after him. They are not allowed to give any kind of injections or irrigations. The scope is limited. It is only about 1% that is done by the registered nursing assistant.

THE CHAIRMAN: Mr. Goulet?

MR. GOUTIER: I am interested mainly in the areas outside metropolitan areas and I understand that your Association is mainly in a couple of metropolitan areas; in Hamilton and Toronto?

MISS GUILLET: Our Association is, yes.

MR. GOUTIER: I believe you said a while ago that you thought there were enough nurses probably to cover the entire province if this were expanded in 1963 to the nursing profession. If it were expanded to cover all of the rural areas and Northern Ontario, and so forth, wouldn't there be considerable conflict with the public health nurses and the Victorian Order of Nurses, or can you speak for these particular people as well?

MISS GUILLET: I cannot speak specifically for the group. In our brief, we continually refer to "visiting nurses' programs," and there are only two - the Victorian



1 identical; what would apply to them would apply to us, and vice
2 versa. Our thinking on the rural areas, some of the health
3 units - that is our official health departments - do provide
4 nursing care on a very limited basis, where there is no other
5 means to obtain a nurse. But in many of the small towns and
6 small rural areas, they do have a one-nurse office.

7 THE CHAIRMAN: Mr. Coulter, there will be a
8 presentation made by the Victorian Order of Nurses and as they
9 are a national or provincial body, probably they would be
10 better qualified to answer that question.

11 MR. COULTER: Yes, Mr. Chairman.

12 THE CHAIRMAN: Are there any other questions?

13 MRS. AYLEN: In large hospitals, they have a
14 medical-social department. Do you have an affiliation with
15 any of them around Toronto? Do you have referrals?

16 MISS QUIGLEY: Yes. We do have referrals. A
17 great number of referrals come from the various hospital
18 social workers. But, one hospital has a medical-social depart-
19 ment and other hospitals have a hospital health service.

20 MRS. AYLEN: That is the same thing?

21 MISS QUIGLEY: Yes, it is the same thing. We
22 have frequent referrals from them. This is why I say we have
23 this close working arrangement. There is a continuity of
24 service. This is no problem. If referrals from hospitals for
25 everything else worked as well as that, we wouldn't have any



ONTARIO NURSES' ASSOCIATION
1914

identical; what would apply to them would apply to us, and vice versa. The fact is that the nursing profession is a very broad one, and it is not possible to have a small nursing office. But in many of the small towns and means to obtain a nurse. But in many of the small towns and small rural areas, they do have a one-nurse office.

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1 problems.

2 MRS. AYLEN: But you do not have a representative
3 in the hospital?

4 MISS QUIGLEY: No. They, in turn, would refer
5 it out to us if it is a visiting nurses' program.

6 THE CHAIRMAN: Mr. Whitney?

7 MR. WHITNEY: Miss Quigley, I want to be clear
8 on a couple of your statistical comments. How many registered
9 nursing assistants do you have?

10 MISS QUIGLEY: Three. This has, up until quite
11 recently, been known as the certified nursing assistant, but
12 within the year they've changed the terminology to the
13 registered nursing assistant.

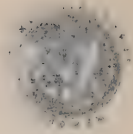
14 MR. WHITNEY: Are all the rest of the 22 R.N.'s?

15 MISS QUIGLEY: Yes; and, as I say, at the
16 present time, 17 of them having advanced training in public
17 health.

18 MR. WHITNEY: I notice that in certain cities
19 and towns the Victorian Order actually works as the public
20 nurse under the medical health officer. Waterloo, Ontario,
21 is one of those and, of course, they get referral work on
22 behalf of the City.

23 Do you get referrals from the medical health
24 officer in your area?

25 MISS QUIGLEY: Yes, in our area it's on a larger



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MISS QUICKLEY: Yes, in our area it's on a larger



1 basis. It comes through the Public Health Nursing Division.
2 You see, in small areas the visiting nurses' services are
3 purchased by the local health department.

4 MR. WHITNEY: Is that a large percentage of
5 your referral work?

6 MISS QUIGLEY: It's a fair bit.

7 MRS. ENRIGHT: I would say not too much per se,
8 say, from the local health department. Certainly from
9 hospitals, so that the social services is a branch of this,
10 but taking it as a local health department, I would say only
11 about 10 to 15 per cent.

12 MR. WHITNEY: What percentage of your work is
13 initiated by the person calling you, without any doctor in
14 the picture initially?

15 Do you get much of that?

16 MRS. ENRIGHT: I'd say about a quarter.

17 MR. WHITNEY: Twenty-five per cent?

18 MISS QUIGLEY: Which we, in turn, have to verify
19 with the doctor before we can go in.

20 THE CHAIRMAN: You can go in for one call,
21 though, first?

22 MRS. ENRIGHT: Frequently when they do call
23 we can ask them if they have a physician, and we would get in
24 touch with the doctor before making even the initial call.

25 When you say patient, this may include a



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1 patient's family, or a friend.

2 MR. WHITNEY: I'm thinking of someone in some
3 household 'phoning your office and saying, "We would like to
4 have the nurse come and see us."

5 MRS. ENRIGHT: If they have a physician we
6 would get in touch with him before making the initial visit.
7 If they do have a doctor.

8 MR. WHITNEY: Have you any knowledge of the
9 names of plans that have major bills? Do you know any specific
10 names?

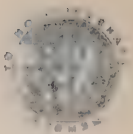
11 MISS QUIGLEY: Canada Life is one that has paid.
12 What about the one that wouldn't pay? Do you want that one?
13 There was one out in B.C., but I don't know the name of it.

14 MR. WHITNEY: Well, there aren't many, or they'd
15 come readily to your memory?

16 MRS. ENRIGHT: There are some of the large
17 industries have a plan that pay about, maybe, it's 80% of the
18 cost.

19 MR. NAYLOR: All of these major medical plans
20 wouldn't pay 100%. They'd have co-insurance, but in any major
21 group plans that I'm aware of they would pay for registered
22 nursing on that basis.

23 MRS. ENRIGHT: We have the odd patient who has
24 medical insurance, and these plans will pay for private duty
25 nurses at \$17.50 per day, but they won't pay for visiting



patient's family, or a friend.

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household, phoning your office and saying, "We would like to

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MRS. ENRIGHT: We have the odd patient who has

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1 nurses.

2 MR. NAYLOR: What kind of plan was that?

3 MRS. ENRIGHT: I can get you the name of it.

4 THE CHAIRMAN: Are there any further questions?

5 I have one other question.

6 How much are you paid by the public health
7 service for your services?

8 MISS QUIGLEY: It's paid in a lump sum, as a
9 grant, but it's based on -- at one time it was \$3 an hour.
10 Different municipalities pay it differently, though. One
11 municipality is paying us on the basis of \$3 an hour, and
12 another municipality gives us a straight grant of \$400.

13 THE CHAIRMAN: Do you have any further comments,
14 Miss Quigley?

15 MISS QUIGLEY: No, I haven't, Mr. Chairman,
16 except to thank the group for their kindness to us.

17 THE CHAIRMAN: Thank you very much. Is the
18 delegation here from the Canadian Mental Health Association?

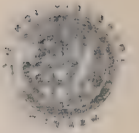
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20 SUBMISSION OF THE CANADIAN MENTAL HEALTH ASSOCIATION

21 Appearances: Mrs. G.C.V. Hewson
22 Dr. Paul Christie
23 Mr. Donald Sinclair

24 THE CHAIRMAN: Which one is to be the spokesman?

25 MR. SINCLAIR: I am, sir. We anticipate to be
joined by our President, Mrs. Hewson, at any moment.



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THE CHAIRMAN: Thank you very much. Is the

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REPORT OF THE CANADIAN MENTAL HEALTH ASSOCIATION

REPORTER: MR. D.O.V. HENSON
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THE CHAIRMAN: Which one is to be the spokesman?

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joined by our President, Mrs. Henson, at any moment.



1 THE CHAIRMAN: I see, but you will continue to
2 be the spokesman, Mr. Sinclair?

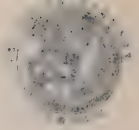
3 MR. SINCLAIR: Yes, sir.

4 THE CHAIRMAN: Do you wish to proceed?

5 MR. SINCLAIR: Yes. I would like to thank you
6 and the Committee for giving us the opportunity of presenting
7 a brief to you, and for the opportunity of meeting with you
8 here today.

9 Coming from the Canadian Mental Health Associa-
10 tion, Ontario Division, which is a lay organization, this is a
11 layman's brief, and I think the only two things, perhaps,
12 that might be commented on prior to whatever discussion you
13 wish to enter into on the brief are the question of the stigma
14 which attaches to mental illness, and the question of finan-
15 cial arrangements for those who are mentally ill.

16 As an Association that has been concerned for
17 many years with the whole question of mental illness, our
18 Association is extremely concerned with this question of the
19 stigma that does attach to it, a stigma which I don't think
20 anyone today would deny exists, and it is no comfort to recog-
21 nize that this stigma is perhaps due to an historical perspec-
22 tive, when the mentally ill were considered as being people
23 who were criminals, or possessed of the Devil, or that it was
24 related to the need for custody, which sprang forth from, or,
25 in turn, was reinforced by this historical view.



THE CHAIRMAN: I see, but you will continue to

be the spokesman, Mr. Sinclair?

MR. SINCLAIR: Yes, sir.

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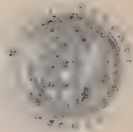
who were criminals, or possessed of the Devil, or that it was

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1 Although it is true that we feel that, to some
2 extent, this stigma has decreased as public attitudes have
3 changed, so that the mentally ill are to a greater degree
4 looked upon as being sick people, and lessened, perhaps, too,
5 because custody is no longer the necessity that once it was,
6 we still feel that a great deal of stigma remains, and we feel
7 that there are, perhaps, three reasons why the stigma still
8 attaches to mental illness, and the third of these, I think,
9 is very germane to our brief. We would accept that mental
10 illness does not evoke the sympathy that physical illness
11 does. I think that despite the work of various groups public
12 attitudes change very slowly, but I think the third and most
13 important one as far as our brief is concerned is that we
14 really believe that the greatest reason, perhaps, for the
15 stigma still remaining is the difference in the manner in
16 which the service to the mentally ill is, in large part,
17 administered.

18 In other words, the physically ill is treated
19 in a normal, or general hospital, by his own practitioner, or
20 by a specialist, while the mentally ill, to a large extent,
21 are treated in special hospitals, special in the sense that
22 they are treated by salaried physicians, and the average man
23 considers this to be an inferior service, rightly or wrongly,
24 simply because it is different, that he doesn't look upon
25 this as being a normal illness, because it isn't treated in the



Although it is true that we feel that, to some extent, this stigma has decreased as public attitudes have changed, so that the mentally ill are to a greater degree looked upon as being sick people, and lessened, perhaps, too, because custody is no longer the necessity that once it was, we still feel that a great deal of stigma remains, and we feel that there are, perhaps, three reasons why the stigma still attaches to mental illness, and the third of these, I think, is very germane to our brief. We would accept that mental illness does not evoke the sympathy that physical illness does. I think that despite the work of various groups public attitudes change very slowly, but I think the third and most important one as far as our brief is concerned is that we really believe that the greatest reason, perhaps, for the stigma still remaining is the difference in the manner in which the service to the mentally ill is, in large part, administered.

In other words, the physically ill is treated in a normal, or general hospital, by his own practitioner, or by a specialist, while the mentally ill, to a large extent, are treated in special hospitals, special in the sense that they are treated by salaried physicians, and the average man considers this to be an inferior service, rightly or wrongly, simply because it is different, that he doesn't look upon this as being a normal illness, because it isn't treated in the



1 same way that other illnesses are treated, and that the
2 service, to a very large extent, is a tax-supported service,
3 and his physician or specialist isn't paid on a fee-for-service
4 basis.

5 We feel that this stigma is one that not only
6 affects the patient, or his friends, or his relatives. We
7 think that it also, perhaps - and this is less often noted -
8 discriminates against the medical profession. Firstly, we
9 believe that this impedes the full integration of all psychia-
10 tric services with general medical services; and, secondly, we
11 believe that it may well impede the exchange of ideas and
12 experience among doctors who are working in different aspects
13 of medicine.

14 This, we believe, is very important today,
15 simply because as the impact of present industrial society
16 increases, so does the stress and the tension increase on the
17 average person, with the inevitable result that the general
18 practitioner is increasingly dealing with neuroses and disturbed
19 people, and therefore we feel that he should be up to date in
20 his knowledge, and this we feel is more likely if he is brought
21 into constant contact with the psychiatrist.

22 These, then, are the comments we would like to
23 make in connection with the question of the stigma attaching to
24 mental illness.

25 In connection with finance, it is the feeling of



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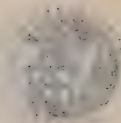


1 our Association that very likely costs will be a factor in
2 arguments that are advanced to leave things as they are, and
3 it's strange, perhaps, but true that while individually people
4 will admit to the fact that the mentally ill are, in fact,
5 discriminated against, they'll smother their conscience with
6 rationalizations and platitudes to the effect that "This is
7 all very true, but we can't afford it to be otherwise."

8 Mr. Chairman, our question is not "Can we
9 afford it?" but "Can we afford to continue without it?"

10 I think that humanitarian reasons alone dictate
11 that a situation which is no more than a historical relic
12 shouldn't be perpetuated. We consider that it is inhuman to
13 continue to look indifferently at the plight of the mentally
14 ill, and we believe that this Committee has a magnificent
15 opportunity, not only to show that it is not indifferent, but
16 to show that it is prepared to move in a direction which will
17 do more to remove the stigma attaching to mental illness than
18 any other single action could achieve.

19 Nobody will pretend, least of all our own
20 Association, that the kind of change that we propose in the
21 brief to the Bill will not cost money. We know that it will,
22 but we also know that the total cost of the additional services,
23 or the change in the administration of services that we propose
24 -- this cost can so easily be exaggerated. We contend that
25 however much it may be, and we believe it to be relatively



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a very true, but we can't afford it to be otherwise."

afford it?" but "Can we afford to continue without it?"

I think that humanitarian reasons alone debate

that a situation which is no more than a historical relic
shouldn't be perpetuated. We consider that it is inhuman to
continue to look indifferently at the plight of the mentally
ill, and we believe that this Committee has a magnificent

opportunity, not only to show that it is not indifferent, but

do more to remove the stigma attending to mental illness than

Nobody will prevent least of all our own

Association, that the kind of change that we propose in the
bill to the Bill will not cost money. We know that it will,



1 small, it can't be compared with the untold cost that the
2 present situation perpetuates in terms of human grief and
3 misery, in terms of the cost of loss of working time, loss of
4 production, plus increased dependency and so on.

5 But, humanitarian considerations aside from the
6 financial viewpoint, again we state that we doubt whether the
7 question is "Can we afford it?" We believe it to be "Can we
8 afford to continue without it?"

9 We haven't done cost studies of our own, but
10 we have had the benefit of cost studies that have been done
11 by other groups, other organizations, both in Canada and in
12 other countries.

13 Our brief indicates that in each of the areas
14 that we discuss, as far as costs are concerned, the cost of
15 consultation, the cost of treatment to the acutely ill, the
16 cost of domiciliary care, the cost of chronic care, we have
17 indicated figures that we have arrived at from several
18 sources.

19 We have studied, for example, the experiment
20 that was carried out in Worthing, in Britain, in New York.
21 We have taken the figures that have been provided to us by the
22 Civil Service Fund in Ottawa, and we believe that the figures
23 we come up with, thirteen million dollars, or approximately
24 two dollars per person resident in Ontario, are a fairer and
25 more true estimate than some which have been widely quoted.



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the same for other countries, in this case, is a fairly good
figure.



1 I think that's all as far as our introduction
2 is concerned, Mr. Chairman, except that I would like your
3 permission to ask Dr. Christie if he would speak on some
4 further points.

5 DR. CHRISTIE: I would like to stress that our
6 Association, I believe, supports the general principles and
7 philosophy of Bill 163 insofar as they support the individual
8 doctor-patient relationship, which is of vital importance in
9 relation to mental illness, even more so than in the physical
10 field, and insofar as it promotes and encourages the indivi-
11 dual citizen's awareness of his own implication, and his own
12 participation in safeguarding and protecting and improving his
13 health.

14 Here again, this individual awareness of parti-
15 cipation is of particular importance in the treatment of these
16 conditions, so that's a general comment on our attitude to
17 Bill 163 as a whole.

18 I would just also like to underline the point
19 that Mr. Sinclair made that this is a lay brief. The cost
20 figures quoted are given at this time chiefly for example,
21 simply as an illustration of what we're trying to say. They
22 have been obtained, as Mr. Sinclair says, from other bodies,
23 who have studied the matter in much more detail, and with
24 much more expert awareness of the Bill, and this will be
25 presented to this Committee, we understand, in later hearings.

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1 So that we felt that the important aspect of
2 this brief today is the general one, the question of the prin-
3 ciple of equal and integrated services.

4 THE CHAIRMAN: Thank you, Dr. Christie and Mr.
5 Sinclair. We also recognize the presence of your President,
6 Mrs. Hewson.

7 Some of the members of the Enquiry have indicated
8 the desire to ask you questions.

9 MISS CARPENTER: Mr. Sinclair, we were
10 interested in the question of costs, of course, and on page 4,
11 paragraph 10. In general hospitals, is the payment for them
12 at present handled differently than for those in the special
13 hospitals?

14 MR. SINCLAIR: Yes, indeed.

15 MISS CARPENTER: Could we have some clarifica-
16 tion on the payment system for units in general hospitals?

17 MR. SINCLAIR: Again, may I ask Dr. Christie
18 to answer this from his experience?

19 DR. CHRISTIE: If I understand Miss Carpenter
20 correctly, I would answer that there is a good deal of variety
21 in how medical services are handled for the mentally ill in
22 general hospitals. Some of them do now possess coverage under
23 plans which provide payment for the services, and they are
24 covered, for example, under Physicians & Surgeons Incorporated.
25 Others pay their own way. In all cases for the private patient



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1 in the general hospital there is a charge, which is paid in
2 one way or another, but it's all different from the mental
3 and psychiatric hospitals, in which the entire service, the
4 hospital service, nursing service, and medical care, is exclu-
5 sively from the tax fund.

6 MISS CARPENTER: Does the Ontario Hospital
7 Services Commission pay for patients in the psychiatric units
8 in general hospitals now?

9 DR. CHRISTIE: Yes, it does.

10 MISS CARPENTER: These estimates of cost on
11 page 4, paragraph 10. The statement is that at presently
12 accepted rates, psychiatric consultation services to all these
13 patients could be provided at an annual cost of about \$1 million
14 --- and then further on, in paragraph 12 we have the estimated
15 cost for the medical care of patients at \$5 million.

16 In paragraph 13 we have \$2 million.

17 Should these be added together to make the
18 total?

19 DR. CHRISTIE: Yes. These were given only as
20 examples. To make up the total there's the cost of out-patient,
21 ambulatory psychiatric care, which would be another \$5 million.
22 Paragraph 12 refers to continuing care and treatment.

23 MR. SINCLAIR: This figure is arrived at on the
24 basis of the figures that were studied in the Worthing experi-
25 ment, the Ottawa Civil Service, and the New York survey, each



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1 of which came up with the figure of eight per thousand of the
2 population would require this type of consultative care, that
3 is each year.

4 MISS CARPENTER: There's just one more question,
5 Mr. Sinclair, in relation to paragraph 14. It is pointed out
6 that the care now being given is substantially below the stan-
7 dards of care for other kinds of patients.

8 In a prepayment plan one would assume that
9 these standards would have to be brought up to the general
10 average, so your costs are lower than they would be if the
11 care were brought up to the average for all other patients?

12 MR. SINCLAIR: We've tried to allow for this in
13 the figure that we arrive at on the number of patients
14 requiring acute treatment in the Ontario hospitals, but I
15 agree with your statement that certainly we would hope that
16 improved standards of care -- this is precisely why we're
17 objecting to the exclusion of the treatment of the mentally
18 ill in paragraph 4, Schedule A.

19 DR. CHRISTIE: Actually, the figure in para-
20 graph 12 is five million for acute treatment in general and
21 mental hospitals. This is based on a staff ratio much
22 greater than would be available for the next ten years. It's
23 based roughly on the American Psychiatric Association standards.
24 So this is the feeling. This would imply, for example, that
25 there were about 600 psychiatrists in clinical practice in



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1 Ontario, whereas there are less than 300.

2 DR. HAMILTON: Mr. Sinclair, could you tell me
3 how many? You said there are less than 300 psychiatrists in
4 Ontario.

5 DR. CHRISTIE: In Ontario clinical practice.

6 DR. HAMILTON: And this includes all the psychia-
7 trists employed in the medical hospitals. You list a large
8 number of patients and treatment. Is it implied that all this
9 treatment must be given by psychiatrists?

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12 MR. SINCLAIR: Where we refer to acute cases,
13 we act on this assumption, that these would be people who
14 will require treatment by psychiatrists.

15 DR. HAMILTON: We're particularly interested in
16 costs, and is it fair to ask what is the cost of treatment for
17 one patient who has an acute psychiatric illness?

18 MR. SINCLAIR: This I would prefer the psychia-
19 trist to answer.

20 DR. CHRISTIE: I'm sure Dean Hamilton is aware
21 that this is very hard for us to answer, because of the range
22 of different kinds of illnesses, but experience with general
23 hospital treatment, which has been demonstrated to be appli-
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1 have to be longer than three or four weeks today in the major-
2 rity of cases, but during that time the medical care ranges
3 in the average at around 200 to 250 dollars, and the out-
4 patient can be handled again for the large majority on the
5 basis of certainly not more than 50 visits per year. That is,
6 again, what this \$5 million of ambulatory care is based on.
7 This limitation is proposed.

8 DR. HAMILTON: One patient might have 50 visits
9 in a year at a specialist; right?

10 DR. CHRISTIE: Yes, at a specialist, right,
11 and this might then be around a thousand dollars in addition
12 for the out-patient care. That's the extreme, the cut-off
13 point which these other groups are suggesting which is all
14 that should be covered in medical care insurance.

15 DR. HAMILTON: The cost of treatment of an
16 acute illness, the medical costs might be \$500.

17 DR. CHRISTIE: In that range, sir.

18 DR. HAMILTON: Plus the cost of hospitalization?

19 DR. CHRISTIE: Yes.

20 MR. SINCLAIR: Another way of looking at this
21 might be that in arriving at this figure we took cognizance
22 of the public service plan and the American Civil Service plan,
23 where it was found that roughly 2% of total insurable costs
24 could be traced to acute treatment cases, but this was one way
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1 DR. HAMILTON: You refer to the present situa-
2 tion as not being satisfactory. I'm not quite clear what you
3 mean.

4 Do you mean the -- I think I'll just ask you.

5 What do you mean by the present situation not
6 being satisfactory?

7 MR. SINCLAIR: Well, not being satisfactory in
8 the sense that, firstly, in the sense that it, as I said
9 earlier, helps to perpetuate the stigma. The fact that this
10 is a large group of mental patients in the province treated
11 in a different way to the manner in which patients suffering
12 from other illnesses are treated.

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15 They are treated in this way because they are
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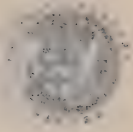
17 DR. HAMILTON: And you are implying that this is
18 not a good service?

19 MR. SINCLAIR: I'm implying that it's different
20 to the manner in which any other illness is administered. The
21 services for the other illnesses are administered.

22 DR. HAMILTON: Are you asking, then, that the
23 mental hospitals should be covered by The Insurance Act?

24 MR. SINCLAIR: Exactly.

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1 be on a fee-for-service to the psychiatrist?

2 MR. SINCLAIR: Right.

3 DR. HAMILTON: And that, therefore, there would
4 be abolition of the government psychiatric service; is that
5 what you mean?

6 MR. SINCLAIR: That's correct. I think there
7 wouldn't only be abolition of this, sir, but there would be
8 abolition of a good deal of the apprehension and fear and
9 anxiety with which people look at mental illness.

10 DR. HAMILTON: You would abolish the mental
11 hospitals, then?

12 MR. SINCLAIR: No. We would reorganize them.

13 DR. CHRISTIE: This wouldn't be done overnight.

14 DR. HAMILTON: I think it's most important that
15 we understand exactly what you mean, and I'm still not clear
16 what you mean about the existing mental hospitals.

17 You say that they can't be abandoned?

18 MR. SINCLAIR: Right.

19 DR. HAMILTON: Because some patients need custo-
20 dial care, or do they?

21 MR. SINCLAIR: No, I don't say that they can't
22 be abandoned because some people need custodial care. There's
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1 of acute psychiatric beds.

2 DR. HAMILTON: When you said that the service
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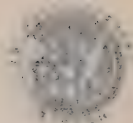
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8 general hospital, depending on the need of the patient.

9 This is not true at present. There's no
10 continuity of care, because the patient is handed over to the
11 separate, government-run service, which can't be integrated
12 with the community service.

13 DR. HAMILTON: I come back to another question
14 I asked earlier.

15 If all of this treatment must be given by the
16 certified psychiatrist.

17 DR. CHRISTIE: By no means. We quoted these
18 figures defining it through the cost of the specialist care,
19 but the Association recognizes and strongly supports the
20 participation of, for example, the family doctor, in the care
21 of the mentally ill, which is already happening in many ways,
22 and which is, to some extent, covered by medical insurance now
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1 reports it in some other way.

2 DR. HAMILTON: Do you feel that if all mental
3 illness were insured, and paid for on a fee-for-service basis,
4 that this could be done at an approximate cost of \$2 per head
5 of the total population of the province?

6 MR. SINCLAIR: Yes.

7 DR. CHRISTIE: And this entire sum would not
8 be expended in this way immediately. This would provide a
9 large cushion, because these developments obviously couldn't
10 happen in one or two years. It would take at least ten years
11 to carry out this type of organization and the change of
12 administration which is being considered.

13 So that we believe that the insurance carriers
14 do not, in fact, need to be apprehensive of the effect of
15 making Bill 163 cover these conditions.

16 DR. HAMILTON: If I could ask you one further
17 question about the mental hospitals, where you state there
18 should be a change in administration, should these become,
19 then, public general hospitals under the Ontario Hospital
20 Services Commission? Is this what you mean?

21 MR. SINCLAIR: This is what we envisage, yes.

22 DR. CHRISTIE: We didn't put this in the brief,
23 because this is about medical services, but clearly the same
24 argument applies to hospital service. This can be taken as
25 implied. You couldn't have one without the other.



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1 MR. MAJOR: Mr. Sinclair, your brief has
2 interested me very much. In fact, I find parts of it fascina-
3 ting.

4 You are aware that psycho-therapy in a large
5 sector of the insurance industry isn't considered insurable.
6 In page 1 you say it is insurable. Do you know that experimen-
7 tation is going on by certain segments of the insurance industry
8 to find out whether or not this phase of ~~mental health care~~ is
9 insurable? On page 3 of your brief, in paragraph 9, the
10 last line, you say:

11 "---insurance must cover the cost of care
12 in any of these settings as needed by the
13 patient."

14 Who determines this; the patient or the physi-
15 cian?

16 MR. SINCLAIR: Oh, no. The physician determines
17 this.

18 MR. MAJOR: This patient hasn't the mentality
19 to do it, has he?

20 MR. SINCLAIR: No.

21 MR. MAJOR: You want this service rendered on
22 the same basis as the service rendered for a tonsillectomy,
23 but the people who you are working on in this case do have
24 the mentality to determine something. They are motivated.
25 They want to go back to work. They want to be well.

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They want to be well. They want to be well.



1 What's the difference in treating this patient,
2 and in treating the psychopathic patient? Isn't there a
3 difference?

4 MR. SINCLAIR: Are you inferring, sir, that
5 anyone who is suffering from some mental disturbance is more
6 likely not to be motivated into going back to work?

7 MR. MAJOR: That's right. Is this a degree of
8 the mental condition, or is it common to all mental patients?

9 MR. SINCLAIR: Well, when you say is it common,
10 is what common?

11 MR. MAJOR: This motivation.

12 MR. SINCLAIR: I would say, on the basis of
13 those that we deal with, I would say that the vast majority
14 wish to be perfectly well again, and return to work, and resume
15 a normal occupation.

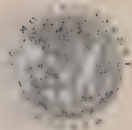
16 MR. MAJOR: This vast majority, then, are people
17 who aren't put into any kind of a mental institution?

18 DR. CHRISTIE: It includes them.

19 MR. MAJOR: In other words, the person that is
20 in a mental institution is mentally well enough to consider
21 the motivation of going to work and living normally?

22 MR. SINCLAIR: Depending on the stage of his
23 illness.

24 MR. MAJOR: What would you consider the words
25 "a patient who should be in a mental hospital"? In other



What's the difference in treating this patient,

and in treating the same patient in a mental hospital?

11

MR. SINGLAIR: Are you inferring, sir, that

anyone who is admitted to a mental hospital is

likely to be a danger to himself or others?

MR. MAJOR: That's right. Is this a degree of

the mental condition, or is it a matter of all mental patients

MR. SINGLAIR: Well, when you say it is common,

12

MR. MAJOR: This motivation.

MR. SINGLAIR: I would say, on the basis of

those that we deal with, I would say that the vast majority

wish to be perfectly well again, and return to work, and resume

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in a mental institution is mentally well enough to consider

the motivation of going to work and living normally?

MR. SINGLAIR: Depending on the stage of his

illness.

MR. MAJOR: What would you consider the words

"a patient who should be in a mental hospital"? In other



1 words, a certificate issued by a member of the medical profes-
2 sion, or two of them, is necessary to put a patient into a
3 mental institution?

4 DR. CHRISTIE: It's one now.

5 MR. MAJOR: Therefore, it takes one doctor now
6 to certify a person to a mental hospital.

7 If they don't go in what do you do?

8 DR. CHRISTIE: We get many applications for
9 admission to mental hospital, who, in fact, respond in the
10 interval between the time the application is made -- respond
11 to treatment.

12
13 This is a medical act, a medical consultation.
14 The question of hospital admission is decided for the psychia-
15 tric, just as it is for the surgical patient by the family
16 doctor, with or without ---

17 THE CHAIRMAN: Is it the intent of your question,
18 Mr. Major, to find out how they are treated if they don't go
19 in?

20 MR. MAJOR: What are we going to do about people,
21 and if this extension can be sawed off some place now, with the
22 idea of extending it in the future, and let's say the extension
23 in the future will be held out to those people who you say you
24 can't afford to get rid of from your mental hospital because
25 they require this kind of custodial care? How do we know how



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1 to get the people out, and know that they are the people who
2 should be out?

3 MR. SINCLAIR: You're drawing a parallel between
4 a physically ill person and a mentally ill person. In the case
5 of a mentally ill person, the possibility is that he will be
6 neither willing nor able to go back to work.

7 MR. MAJOR: Yes, particularly he is not willing
8 because he isn't logical.

9 MR. SINCLAIR: I think that this is a completely
10 false assumption. The point is that if he is mentally ill,
11 is he ill or not? If so, he's obviously not able to go to
12 work.

13 MR. MAJOR: In other words, we shouldn't neces-
14 sarily have faith in the practitioner who is treating us?

15 MR. SINCLAIR: I'm sorry. I don't understand.

16 THE CHAIRMAN: I think that needs further
17 clarification, Mr. Major. I don't understand it either.

18 MR. MAJOR: I'll withdraw the question.

19 Now, on page 3, in paragraph 8, this theme of
20 mental illness must be treated in the same social and economic
21 framework as other illnesses.

22 This particular theme has never been refuted.

23 Can you give us an example of how successful you've been? It
24 may not have been refuted, but how well has it been proved?

25 What has been done to prove that mental illness responds to



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MR. MAJOR: I'll withdraw the question.

Now, on page 3, in paragraph 8, this theme of

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What has been done to prove that mental illness responds to



1 treatment better, and that we are more successful as a society
2 treating these people the same as we treat every other illness,
3 that is, by putting them into a mental institution?

4 MR. SINCLAIR: I think that there's this first
5 answer to this, that when this is done, that is done in the
6 sense of treating someone in the psychiatric wing of a general
7 hospital, it has proven to be successful.

8 DR. CHRISTIE: The figures on that for 1962,
9 there are only 545 psychiatric beds, roughly, in the province
10 in general hospitals, but in 1962 they admitted 6,500 cases.
11 This compares to about double the number treated in the mental
12 hospitals, with about four times the number of beds.

13 MR. MAJOR: Were these people ever in a
14 mental institution?

15 DR. CHRISTIE: Many of them were.

16 MR. MAJOR: So that, because they had been in
17 a mental institution, and no progress was made, they were then
18 put into a wing of a general hospital?

19 DR. CHRISTIE: No. The cases I'm thinking
20 about had been in a general hospital; they had returned home
21 and relapsed, and now, because they have insurance, or
22 services have been opened up, they are admitted to a general
23 hospital, and they again respond to treatment.

24 MR. MAJOR: Sheltered living arrangements; is
25 that mental institutions?

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that mental institutions?



1 DR. CHRISTIE: Both in and out, yes.

2 MR. MAJOR: In this stigma that applies to the
3 mental patient, you've set forth the matter of sympathy, and
4 the public attitude, and the difference in service, and you
5 stress the difference between salaried physicians and fee-for-
6 service, as I understand it, and I want clarification on this.

7 Do you feel that the patient is going to get
8 better faster if the doctor is paid fee-for-service?

9 MR. SINCLAIR: Let's put it this way, sir. I
10 think if this is the conclusion that's drawn from our document,
11 I feel that it's a pity.

12 All that we're saying is that I think we would
13 all recognize that it's difficult for the Ontario hospitals
14 to attract psychiatrists. We feel that because of this the
15 ratio of psychiatrists to patients isn't all that we would
16 hope it would be.

17 We feel that if psychiatrists came into the
18 hospital to treat their patients in the way that specialists
19 in other fields of medicine do, that this situation would be
20 greatly improved, and therefore standards of care would be
21 improved.

22 MR. MAJOR: Going back to your first statement,
23 that there has been difficulty getting psychiatrists to work
24 in hospitals, I wonder why it has been difficult?

25 MR. SINCLAIR: I can only say that it happened.



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1 We've had some cases within the last few months, clinics have
2 had to be closed because the -- the North Bay Clinic is an
3 example. We can point to Ontario hospitals where it isn't
4 possible for them to attract psychiatrists.

5 Now, to ask me why this is so, I think that
6 there may be very good reasons for this, but significantly it
7 isn't this difficult to attract a psychiatrist to work in the
8 psychiatric wing of a general hospital.

9 MR. MAJOR: What I was trying to come to, Mr.
10 Sinclair, is why - in paragraph 14, you say that the methods
11 of financing facilities of which one is tax-supported and the
12 other is fee-supported. I would gather that you don't like the
13 tax-supported proposition?

14 MR. SINCLAIR: We do not like the difference.
15 It is the difference that we object to, the fact that mental
16 illness is not treated in the same fashion as other illnesses
17 are. This is one example of this, that the mentally ill are,
18 by and large, the great majority of them, are treated under a
19 system that is tax-supported, whereas people with a physical
20 illness are not. We feel that this differentiation need not
21 happen today and we feel it is one more factor in perpetuating
22 the attitude of the public towards the mentally ill.

23 MR. MAJOR: If you take this person out of the
24 mental hospital and put them into the wing of the general
25 hospital and use the same psychiatrist, they will be better



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MR. MAJOR: If you take this person out of the

mental hospital and put them into the wing of the general

hospital and use the same psychiatrist, they will be better



1 off in the general hospital than they would be in the mental
2 hospital?

3 MR. SINCLAIR: My concern here is not whether
4 this one person will be better off or not. My concern is
5 with the general attitude of the public towards the treatment
6 that a friend is getting.

7 MR. MAJOR: In other words, if Mr. Jones is a
8 patient in a mental hospital, he is going to suffer unduly
9 from the public, in respect to the comparison of his being in
10 a wing of a general hospital?

11 MR. SINCLAIR: It is still true. It is a matter
12 of time. But I say that this process can be quickly changed
13 by accepting the recommendation that we have made in the brief
14 in regard to the question. I do not think you would deny, or
15 any one of us would, that if someone down the street from us
16 breaks his leg or her leg and is taken to the hospital, they
17 send flowers and visit him. If that same person is admitted
18 into a mental hospital, suddenly everyone is very suspicious.
19 He feels that this is different, a hospital is different. We
20 hear this is a place where they lock people up, and so forth.

21 MR. MAJOR: This is a little off the beam, maybe,
22 Mr. Chairman. You can rule it out if you care to. What about
23 the tubercular? He goes to the hospital. They do not have
24 the family physician there. They do not even have the
25 specialist that placed him into this hospital. Should we



off in the general hospital than they would be in the mental

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Mr. Chairman. You can rule it out if you care to. What about

the tuberculosis? He goes to the hospital. They do not have

the family physician there. They do not even have the

specialist that placed him into this hospital. Should we



1 consider pulling tuberculars out of the tubercular hospital?

2 THE CHAIRMAN: Your question is, is the tuber-
3 cular hospital in the same category as the mental hospital?

4 MR. MAJOR: What I was coming to is the
5 surroundings. The hospital for the tubercular, as far as I
6 am concerned, is no better or worse than the surroundings in
7 the mental hospital.

8 THE CHAIRMAN: Their brief is in favour of
9 this one only.

10 MR. MAJOR: I withdraw the question. If, Mr.
11 Sinclair, as time goes on, you decide that, because of this
12 stigma, you will now divorce the psychiatric wing and you will
13 now no longer have a psychiatric wing because it was found out
14 by the neighbours that this chap is in a psychiatric wing, the
15 stigma will be as strong as it was?

16 MR. SINCLAIR: No, sir. This man is being
17 treated in a hospital, just like anyone else is, with a duo-
18 denal ulcer or an infection of the hip or anything else. He
19 is being treated in the same context. He is hospitalized.
20 Therefore, he is sick. He is not weird or strange or criminal
21 or what-have-you.

22 MR. MAJOR: Thank you, sir. I have no more
23 questions.

24 MR. WHITNEY: Mr. Sinclair, on page 1 of your
25 brief, the fourth paragraph, do you have a copy of the Bill

consider pulling underneath out of the tubercular hospital?
THE CHAIRMAN: Your question is, is the tubercular hospital in the same category as the mental hospital?
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MR. SINCLAIR: No, sir. This man is being treated in a hospital, just like anyone else is, with a doubtful ulcer or an infection of the hip or anything else. He is being treated in the same context. He is hospitalized. Therefore, he is alone. He is not weird or strange or criminal or what-have-you.
MR. MAJOR: Thank you, sir. I have no more questions.
MR. WHITNEY: Mr. Sinclair, on page 1 of your brief, the fourth paragraph, do you have a copy of the Bill



1 there on your table? You mention on page 1, and again it
2 comes up on page 5, in Clause 13, you say:

3 "That, in order to effect the above
4 recommendations" -
5 the same on both pages -

6 "paragraph 4 of Schedule A of Bill 163
7 be amended in such a manner that a
8 general exclusion of mental illness
9 from insured medical services will be
10 eliminated."

11 Now, referring to paragraph 4, would you just
12 enlarge on that and tell me what you mean?

13 MR. SINCLAIR: Schedule A, which is a list of
14 the benefits provided - a list of exceptions, actually...

15 MR. WHITNEY: That is right.

16 MR. SINCLAIR: ...of the benefits provided,
17 makes the treatment of the mentally ill in special institutions
18 an exception. In other words, there would be no insurance
19 coverage for someone who was being treated in a mental hospital.

20 Now, we are not suggesting that anyone should
21 pay twice. We are not suggesting that both the physician or
22 psychiatrist should receive a fee for service he has offered,
23 and that, in addition to this, the Government should also,
24 the Department of Health should also be paying out a fee for
25 people who work on a salaried basis for the same patient.



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1 We are suggesting that this exception should
2 be removed and that the whole question of the nature in which
3 the service is operated - that is the service the mentally
4 ill patient gets - is administered differently from what it
5 is today. May Dr. Christie enlarge on that?

6 DR. CHRISTIE: I would like to add to Mr.
7 Sinclair's statement, with which I agree, that this paragraph,
8 as it stands, it is true, does not specifically say that
9 insured benefits can't apply in these places. But it appears
10 to take for granted that because the patient is treated in a
11 particular kind of facility, therefore, by this reason alone,
12 the insured benefit should not apply. So that, in effect, it
13 is perpetuating the present situation. We would like to see
14 this paragraph reworded to say, for example, that medical
15 services are excluded when provided by a physician paid a
16 salary to provide this service, recognizing that for some
17 interim period there still will be salaried physicians.

18 In addition to that, Mr. Chairman, going back
19 to Mr. Major's point, I do not think our Association wishes to
20 take any stand as regards salaried versus fee-for-services.
21 Again, what is emphasized is the uniformity. Whichever method
22 is worked out in Ontario, we feel it should be the same for
23 all illnesses, including mental illness. Whether it be
24 salaries or fees, I do not think we wish to take the position
25 whether medical care is given by a salaried physician or on a

We are suggesting that this exception should be removed and that the whole question of the nature in which the service is operated - that is the service the mentally ill patient gets - is administered differently from what it is today. May Dr. Christie enlarge on that?

DR. CHRISTIE: I would like to add to Mr. Sinclair's statement, with which I agree, that this paragraph, as it stands, it is true, does not specifically say that insured benefits can't apply in these places. But it appears to take for granted that because the patient is treated in a particular kind of facility, therefore, by this reason alone, the insured benefit should not apply. So that, in effect, it is perpetuating the present situation. We would like to see this paragraph reworded to say, for example, that medical services are excluded when provided by a physician paid a salary to provide this service, recognizing that for some interim period there still will be salaried physicians.

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1 fee-for-service basis. I think very good medical care is given
2 by many salaried physicians. This is not the point. It is
3 the difference as regards to the patient and the public atti-
4 tude.

5 MR. WHITNEY: I still do not think we are coming
6 to grips with it. I question the fact that you say there is a
7 general exclusion here. I do not think there is. I would like
8 to know how you see a general exclusion, because the reference
9 to it in the first four lines is modified by the words "where
10 such services are paid for by the sanatorium, institution or
11 special hospital." If I read it correctly, and I stand to be
12 corrected, I do not think there is a general exclusion here.
13 There may be an objection, as you say, to the way it is worded.
14 I mean, this is important to us because we might have to make
15 recommendations on drafting, so I am getting you into drafting
16 and I would like to be clear.

2 17 DR. CHRISTIE: I quite agree.

18 MR. WHITNEY: There is not a general exclusion?

19 DR. CHRISTIE: No. It is the implication of the
20 implementation and we feel a change in wording to stress the
21 person who provides the service, rather than the place where
22 it is provided, would clarify this.

23 MR. SINCLAIR: We would agree that the way the
24 Bill is presently worded, it suggests two alternative facili-
25 ties; one tax-supported and one fee-supported.



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ties: one tax-supported and one fee-supported.



1 MR. WHITNEY: I do not quite see it that way.
2 I think your fee support outside of hospital is quite clearly
3 covered under the very first words of Schedule A:

4 "Necessary professional services of a
5 physician, wherever rendered, unless
6 excepted under this Act or under this
7 Schedule."

8 This is a very broad coverage. Doesn't that
9 cover the fee situation?

10 MR. SINCLAIR: Yes. This covers the fee situa-
11 tion all right.

12 MR. WHITNEY: Yes. And then when we come down
13 to 4, and you may be able to assist us by sending in a re-
14 draft of this, if you wouldn't mind, and then I might be able
15 to make up my mind. When we come down to 4, we are only
16 dealing with such services, to exclude them where such services
17 are paid by the sanatorium, institution or special hospital.

18 Now, the in-hospital fee services, you notice
19 Schedule B which covers another type of suggested contract,
20 so that wherever A does not cover in-hospital services of any
21 kind, Schedule B is being suggested as a type of contract to
22 cover all sorts of medical services in hospital.

23 DR. CHRISTIE: This is correct. But apart from
24 the Schedules, there is also the point of setting the subscrip-
25 tion rate in Section 16 of the Act, where it is now shown



MR. WHITNEY: I do not quite see it that way. I think your fee support outside of hospital is quite clearly covered under the very first words of Schedule A: "necessarily professional services of a physician, whenever rendered, unless excepted under the Act or under this Schedule." This is a very broad coverage. Doesn't that cover the fee situation? MR. SIMON: Yes. This covers the fee situation all right. MR. WHITNEY: Yes. And then when we come down to it, and you may be able to assist us by sending in a re- draft of this, in your written mind, and then I might be able to make up my mind. When we come down to it, we are only dealing with such services to exclude them where such services are paid by the government, institution or special hospital. Now, the in-hospital fee services, you notice Schedule B which covers a number of suggested contracts, so that wherever A does not cover in-hospital services of any kind, Schedule B is being suggested as a type of contract to cover all sorts of medical services in hospital. MR. SIMON: I am in agreement. But apart from the Schedule, there is also the point of setting the subscription rate in Section 16 of the Act, where it is now shown



1 simply as "X, Y, $2\frac{1}{2}X$."

2 MR. WHITNEY: You have to do that for everybody?

3 DR. CHRISTIE: The question is whether the
4 implementation of this Bill takes paragraph 4 as far as
5 suggesting that the existing situation is permanent and there-
6 fore in setting the rates there need be no provision for a
7 change, and changes are already coming about and it is
8 C.M.H.A.'s strong statement that nothing should be done to
9 prevent the continuation of this change. In other words, the
10 continuation of bringing psychiatric treatment back to the
11 framework of medical treatment.

12 MR. WHITNEY: I did not read that implication
13 into it, but it might be more from your point of view that
14 there may be a little permanency implied with this thing?

15 MR. SINCLAIR: This was the Association as a
16 whole's interpretation.

17 MR. WHITNEY: That is the first time anything
18 like that has been suggested. Thank you.

19 THE CHAIRMAN: Dr. Butt?

20 DR. BUTT: I would like to ask one question:
21 what is your relationship with the Division of Mental Hygiene,
22 Department of Health of Ontario?

23 MR. SINCLAIR: With the Mental Health Branch of
24 the Department of Health?

25 DR. BUTT: Yes.



simply as "X, Y, Z & X."

MR. WHITNEY: You have to do that for everybody?

DR. CHRISTIE: The question is whether the

implementation of this Bill takes paragraph 4 as far as

suggesting that the existing situation is permanent and there-

fore in setting the rates there need be no provision for a

change, and changes are already coming about and it is

C.M.H.A.'s strong statement that nothing should be done to

prevent the continuation of this change. In other words, the

continuation of bringing psychiatric treatment back to the

framework of medical treatment.

MR. WHITNEY: I did not read that implication

into it, but it might be more from your point of view that

there may be a little permanency implied with this thing?

MR. SINGLAI: This was the Association as a

MR. WHITNEY: That is the first time anybody

like that has been suggested. Thank you.

DR. BUTT: I would like to ask one question:

What is your relationship with the Division of Mental Hygiene,

Department of Health of Ontario?

MR. SINGLAI: With the Mental Health Branch of

the Department of Health?



1 MR. SINCLAIR: Our relationship with them?

2 DR. BUTT: Yes.

3 MR. SINCLAIR: I work, in my job, with Dr.

4 McNeill, Dr. Henderson and Dr. Lewis because I think each of
5 us should be aware of what we are trying to do.

6 DR. BUTT: The question that follows that is:
7 does this brief, in general, coincide with their feelings?

8 MR. SINCLAIR: I have no idea. This has been
9 a brief presented by our Association, under the guidance of
10 the Scientific Advisory Committee, and we have not consulted
11 the Ontario Department of Health in the preparation of the
12 brief.

13 DR. BUTT: Do you feel that your ideas are in
14 conflict with any of theirs at the present time?

15 MR. SINCLAIR: I would doubt whether they would
16 argue with the principles that we have tried to propound here
17 today, sir.

18 DR. BUTT: Fine. Thank you very much.

19 THE CHAIRMAN: Mr. Mulrooney?

20 MR. MULROONEY: In your presentation and your
21 brief and your explanations this morning, there is implicit,
22 it seems to me, the idea that Ontario Hospital should be con-
23 verted to public general, then?

24 MR. SINCLAIR: Yes.

25 MR. MULROONEY: Are there not incurable mental

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1 illnesses?

2 MR. SINCLAIR: I think there are plenty of
3 individuals that so far the total body of psychiatric know-
4 ledge has not found an answer for; but so, too, are the people
5 who are incurably ill from cancer.

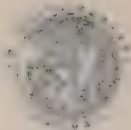
6 MR. MULROONEY: Is it not true that some of
7 these people who are incurably ill do need actual custodial
8 care and possibly for the rest of their lives? I am suggesting
9 here that one of the reasons for, shall we say, pure cures and
10 discharges from Ontario Hospital is the fact that these
11 hospitals must maintain some - how many, I have no idea -
12 persons who are incurable and who will continue to be custodial.

13 MR. SINCLAIR: I do not like the tying in with
14 the term "incurable" the term "custodial." This implication
15 here seems to be that because someone cannot be cured, he must
16 be kept in custody. Now, I know that this might be a semantic
17 problem - a question of what is custody. I would say that
18 because he is incurable, he continues to require care; but I
19 would not accept the principle that he continues to require
20 custody.

21 MR. MULROONEY: I would suggest to you that the
22 custody may be necessary for his own safety or the safety of
23 other people?

24 MR. SINCLAIR: Yes.

25 MR. MULROONEY: And, therefore, would be



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MR. MURPHY: I would suggest to you that the

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other people?

MR. MURPHY: And, therefore, would be



1 necessary for some of these patients?

2 MR. SINCLAIR: For some, yes. Originally, you
3 started off - I understood you meant all people who were incu-
4 rable, who were chronic patients, were in need of custody.

5 MR. MULROONEY: I wanted to bring up the fact
6 that for safety of the patient and his neighbours, custodial
7 care will continue to be necessary in this province.

8 MR. SINCLAIR: For a proportion of the incurable
9 cases?

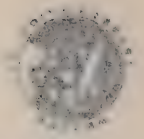
10 MR. MULROONEY: Yes. Whether it was one or
11 10,000 persons, I do not know.

12 MR. SINCLAIR: Yes.

13 DR. CHRISTIE: I would say that the vast
14 majority who need domicile or chronic care do not need it for
15 their own safety and the safety of neighbours, but simply
16 because of their inability to get along under normal conditions.
17 Not safety, but incapacity, similar to a completely crippled
18 arthritic.

19 MR. MULROONEY: I see. I used that to illustrate
20 the fact that continued care for the rest of a person's life
21 will be necessary for some people. This is the point I want
22 to make.

23 DR. CHRISTIE: We do stress that the hospitals,
24 all the hospital services, will have to distinguish between
25 medical treatment and chronic and domiciliary care. These are



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all the hospital services, will have to distinguish between

medical treatment and chronic and domiciliary care. These are



1 different things.

2 MR. MULROONEY: The brief gives us some infor-
3 mation about the Canadian Mental Health Association, its
4 membership, and so on. You mention, for example, the time
5 spent by the volunteer workers. Can you tell us the total
6 sum that is collected by your Association per year and give
7 us some notion of the manner in which this money is disbursed?
8 I would like to know, for example, whether the Canadian Mental
9 Health Association does pay for any professional services of
10 psychiatrists for the mentally ill.

11 MR. SINCLAIR: Yes. I can only speak for the
12 work, or would prefer to limit my comments to the work of the
13 Canadian Mental Health Association here in Ontario. The
14 program that we follow up here is not a treatment program.
15 That is, we are not involved in the actual treatment ourselves
16 with the mentally ill. Our stress is in four areas. One is
17 in finding money for research into mental illness and the cost
18 of treatment thereof; secondly, into giving direct service to
19 those who are mentally ill. This may be service to those who
20 are presently ill in hospital, or could be service to those
21 who are ex-patients.

22 THE CHAIRMAN: Would you mind elaborating what
23 you mean by direct service?

24 MR. SINCLAIR: To patients in hospital?

25 THE CHAIRMAN: Yes.



MR. MURPHY: The brief gives us some infor-

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THE CHAIRMAN: Would you mind elaborating what

you mean by direct service?

MR. SINGH: To patients in hospital?

THE CHAIRMAN: Yes.



1 MR. SINCLAIR: Yes. I was about to do that.
2 We have groups of volunteers who visit people who are mentally
3 ill, who normally would not have anyone to visit them. They
4 may be living in hospitals hundreds or, in some cases, a
5 thousand miles away from home, because they do not have psychia-
6 tric wings in their local hospitals, and they may be people
7 who have no relatives or friends to visit them and we provide,
8 through our volunteer bureau, this kind of visiting service.
9 The service is not only one of visiting and listening, and
10 lending a sympathetic ear to someone who is mentally ill. We
11 also, in various hospitals, do various things. In some
12 hospitals we provide, for instance, a clothing centre.
13 Volunteers run a canteen and put on entertainment. Our volun-
14 teers pay for transportation of relatives and friends to
15 hospitals, when they are far away from home and find themselves
16 unable to raise the money to pay for the cost of this kind of
17 transportation.

18 These are some of the services that we provide
19 to people who are mentally ill and in hospital.

20 In regard to the ex-patient we have, in some
21 centres in Ontario, White Cross centres which are, as we like
22 to call them, "islands of acceptance" for people who have been
23 mentally ill and are trying to make their way back into the
24 community. These are people who are not yet able enough or
25 independent enough or confident enough to go back into their



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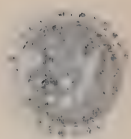
We have groups of volunteers who visit people who are mentally ill, who normally would not have anyone to visit them. They may be living in hospitals hundreds or, in some cases, a thousand miles away from home, because they do not have psychiatric wings in their local hospitals, and they may be people who have no relatives or friends to visit them and we provide, through our volunteer bureau, this kind of visiting service. The service is not only one of visiting and listening, and lending a sympathetic ear to someone who is mentally ill. We also, in various hospitals, do various things. In some hospitals we provide, for instance, a clothing centre. Volunteers run a canteen and put on entertainment. Our volunteers pay for transportation of relatives and friends to hospitals, when they are far away from home and find themselves unable to raise the money to pay for the cost of this kind of transportation. These are some of the services that we provide to people who are mentally ill and in hospital. In regard to the ex-patient we have, in some centres in Ontario, White Cross centres which are, as we like to call them, "islands of acceptance" for people who have been mentally ill and are trying to make their way back into the community. These are people who are not yet able enough or independent enough or confident enough to go back into their



1 own social groups and who need the kind of support and encou-
2 ragement that volunteers and interested staff can give them.
3 We try to use this as a sort of half-way house, if you like,
4 between the stage of mental illness and complete recovery.
5 We have recently in this area of ex-patient care also
6 started a pilot project. In our centre in London, we are
7 starting an industrial rehabilitation program for our ex-
8 patients who have found difficulty in obtaining work and we
9 are joining this with a similar program for those actually in
10 hospital and going out of hospital, on a daily basis, to work
11 in this workshop and develop work habits and patterns before
12 they begin to resume their normal life.

13 A third area that we are tremendously interested
14 in is the whole area of education and in this sense we are
15 perhaps aiming at two groups of people. We are trying to
16 inform the public at large of the scope and magnitude of the
17 problem of mental illness and what this might mean to them
18 and why people should be more interested in it today.

19 Secondly, we aim particularly at special
20 groups of people. Here I am thinking of parents. We have a
21 great number of courses in different communities for parents
22 in co-operation sometimes with home and school associations
23 in trying to impress upon parents the need for acquiring more
24 knowledge in the area of child health and development, so that
25 at least they will not make the kind of mistakes, which are so



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1 easily made, and which can lead to an emotionally disturbed
2 child. The second angle of this program is the work that we
3 do with special people in the community and I would cite here
4 the clergy and guidance teachers and personnel officers,
5 public health nurses, police and other groups who have direct
6 contact with the mentally ill and to whom we try to provide
7 courses, workshops, seminars, conferences, this kind of thing,
8 to obtain training and knowledge of how these people can be
9 detected and how they can be helped.

10 Lastly, the main pillar of our work is what we
11 are doing here today; that is, the social action component of
12 our work. We feel that we must continue to press the govern-
13 ment for that kind of change that we feel is going to help
14 those who are mentally ill and those of us in this room today
15 who may one day be in that situation.

16 MR. MULROONEY: I think one part of my question
17 has not been answered. How much money do you collect?

18 MR. SINCLAIR: Our budget in the Ontario Division
19 this year, or last year, was about \$81,000.

20 MR. MULROONEY: Thank you.

21 MR. SIMON: I am rather concerned, Mr. Chair-
22 man, with the implication made here that there is inferior
23 service or care for these patients because they find themselves
24 in tax-supported institutions and that there may be superior
25 care for them in fee-supported institutions. If this were the



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15 who may one day be in that situation.

16 MR. MURDOON: I think one part of my question
17 has not been answered. How much money do you collect?

18 MR. SINGH: Our budget in the Ontario Division
19 this year, or last year, was about \$21,000.

20 MR. MURDOON: Thank you.

21 MR. SIMON: I am rather concerned, Mr. Chair-

22 man, with the implication made here that there is inferior
23 service or care for these patients because they find themselves
24 in tax-supported institutions and that there may be superior
25 care for them in fee-supported institutions. If this were the



1 case, supposing the Government withdrew the tax support in
2 these institutions, would you find thousands of patients that
3 would be left without care at all?

4 DR. CHRISTIE: I think Mr. Sinclair could say
5 this just as well as me, but this refers to the interim period.
6 For one thing, clearly nobody is going to change the pattern
7 of Ontario hospitals between now and the end of 1964. It is
8 going to take at least ten years to make a major change.
9 There is no question that the services do not measure up. They
10 do not measure up in the number of doctors available for the
11 patients. They do not measure up in the per diem costs
12 available to the acutely ill patient.

13 Comparing a psychiatric hospital unit with the
14 acute beds in Ontario hospitals the dollars available per bed
15 are certainly no better than half. So it is an evolution that
16 we are trying to start here and it is a progressive change
17 which, again, is already happening to a great extent. In
18 some provincial hospitals, there are parts of the hospital
19 which are no longer in the same sense run as government tax-
20 supported services. They are open, informal units in which
21 community doctors treat their patients with as many privileges
22 as they would in the general hospital. This is already being
23 done.

24 It is our concern to see that it goes on being
25 done more and more.

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1 THE CHAIRMAN: Are there further questions from
2 any members of the Enquiry?

3 DR. GALLOWAY: I have one or two. First of all,
4 I should like to compliment this group who made this brief.
5 They are always extremely dedicated to the job and I congratu-
6 late you on what you have done. You are a fairly practical
7 group of people and I am trying to find ways of implementing
8 or making this Act useful in your recommendations regarding
9 the steps that you would recommend to be carried out to
10 procure the aims that you officially want. You say it is
11 impossible?

4 12 MR. SINCLAIR: We do not enter into this field
13 because we think it would be presumptuous of us to attempt to
14 do so. We can only say, as Dr. Christie has already said, that
15 we recognize that if our recommendations were to be accepted,
16 that this will cause a period of transition when administrative
17 arrangements are going to have to be worked out in some detail
18 and a great deal of foresight in planning.

19 We have been negligent - or, rather, we do not
20 consider we have been negligent in not making definite
21 proposals here. We felt that this was outside our scope.

22 DR. HAMILTON: There are out-patient departments
23 for the continuing care of patients now. In this regard, are
24 the same psychiatrists treating patients as in-patients or as
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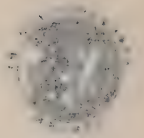


1 DR. CHRISTIE: Some, but not enough yet. This,
2 again, is the lack of uniformity which, again, can be worked
3 out to provide more continuity, if the system were uniform
4 throughout. The out-patient department and the clinic are,
5 at the present time, two separate things.

6 DR. HAMILTON: You have spoken about the atti-
7 tude of the public. What about the attitude of the patient
8 who is required or requested to return to the out-patient
9 department for continuing care? Do you have difficulty in
10 having this patient return to the out-patient department of
11 the institution?

12 DR. CHRISTIE: Generally, no. Once he he has
13 established a treatment relationship with the institution,
14 the majority wish to continue this. This is a feature of all
15 medical practice, that the doctor-patient relationship becomes
16 important and it becomes identified with the setting in which
17 it is given.

18 I would like to comment on Dr. Galloway's first
19 question. Practically speaking, I think the first thing that
20 we would like to see is possibly some re-wording of this para-
21 graph. That may not be necessary, as Mr. Whitney pointed out,
22 but I think by implication the most practical thing is the
23 setting of the basic contract for a subscription fee on page
24 7 of the Bill, and that this may be set realistically to provide
25 specialist services, wherever they are available and can be



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1 given. There will be limitations imposed by the number of
2 specialists available. Utilization cannot go beyond the people
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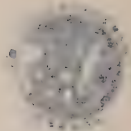
6 MR. WHITNEY: I want to make it clear that I
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8 come in. We have redrafted some that have come before us for
9 consideration, so this is not unusual. If you care to do so,
10 the Secretary will get it and distribute it to us.

11 MR. SINCLAIR: Thank you for the opportunity.
12 We would be very happy to accept.

13 MR. CASWELL: Mr. Chairman, could the members
14 of this Mental Health Association be asked to also give us
15 recommendations as to how they propose this transition might
16 come about? You, no doubt, have given a lot of thought to it.
17 It is quite apparent today that if this information could also
18 be passed on to the Committee, it is possible that the
19 Committee could consider this.

20 MR. SINCLAIR: We would be very happy to do so.
21 We thought it would be presumptuous of us to do this but now
22 that we are invited to, we would be happy to oblige.

23 THE CHAIRMAN: I think that the questions that
24 have been asked would indicate that if you care to elaborate
25 further on this we would be very pleased to take your



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24 have been asked would indicate that if you have the information
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1 recommendations into consideration.

2 MR. SINCLAIR: Thank you.

3 THE CHAIRMAN: Are there any further questions?
4 Do you have any further comments?

5 MR. SINCLAIR: No, sir.

6 THE CHAIRMAN: Thank you very much.

7 Are the spokesmen here for the Ontario Society
8 of Oral Surgeons, as well as the Ontario Dental Association?
9 Are the two spokesmen here? Would you care to come forward
10 for a moment, please?

11 Members of the Enquiry, after a little consulta-
12 tion in confidence here, it has been decided that unless this
13 is objected to by any members of the Enquiry, we will recess
14 now and hear jointly the Ontario Society of Oral Surgeons and
15 the Ontario Dental Association and Royal College of Dental
16 Surgeons after a luncheon recess and possibly, in view of this,
17 in place of re-convening at 2 o'clock, we might be able to do
18 so a little earlier - say, at 1.30; would that be satisfactory
19 to all of you? Then we will re-convene at 1.30.

20

21 --- Luncheon adjournment.

22

23

24

25



recommendations into consideration.

THE CHAIRMAN: Are there any further questions?

Do you have any further comments?

MR. SIMON: No, sir.

THE CHAIRMAN: Thank you very much.

Are the spokesmen here from the Ontario Society

Are the two spokesmen here? Would you care to come forward

for a moment, please?

Members of the Society, after a little consultation

that is a matter of fact in the case of the Ontario Society

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now and hear jointly the Ontario Society of Oral Surgeons and

the Ontario Dental Association and Royal College of Dental

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--- Luncheon adjournment.



dpw 1 --- On resuming at 1:30 p.m.

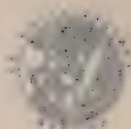
2 THE CHAIRMAN: Now, if I may confirm the arrange-
3 ments which I understood we decided upon previous to lunch;
4 we'll hear the presentation from the Ontario Dental Association,
5 and then the Ontario Society of Oral Surgeons, before we ques-
6 tion the Ontario Dental Association.

7 Members of the Enquiry have received and
8 studied the brief you submitted. In accordance with the guide
9 for participation in hearings that was mailed to you, it will
10 not be necessary for you to read your brief, but you do have
11 an opportunity to emphasize or enlarge upon its conclusions
12 or recommendations.

13 Members of the Enquiry may ask you questions
14 on the statements or recommendations submitted in your brief,
15 but you are not to be subjected to examination or cross-
16 examination by other persons.

17 It is not our intention to debate your sugges-
18 tions or recommendations, nor to state the views of this
19 Enquiry on them. Consequently, any opinions expressed in
20 questions asked or statements made by members of the Enquiry
21 are intended for clarification only.

22 As stated in the instructions, one person is to
23 act as your spokesman. However, if the spokesman feels that
24 another member is better qualified to answer a specific ques-
25 tion from a member of the Enquiry, the spokesman may receive



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Members of the Endury have received and

received and will be interested in the discussion with the public

the discussion in the afternoon will be devoted to you, it will

not be necessary for you to come to the office, but you do have

the opportunity to come to the office and see the committee

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any other person should be permitted to answer a question, that

person may be permitted to answer the question, but the spokesman



1 the Chair's permission to request the other member to answer.

2 The members of the press have requested a copy
3 of your brief, and if you have copies with you, perhaps you
4 will hand them to the members of the press at the conclusion
5 of your submission.

6 Now, gentlemen, who is to be the spokesman,
7 and would you please identify yourself?

8

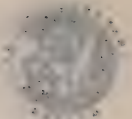
9 SUBMISSION OF THE ROYAL COLLEGE OF DENTAL SURGEONS
10 OF ONTARIO and THE ONTARIO DENTAL ASSOCIATION.

11 Appearances: Dr. J. Coupland
12 Dr. W. Wesley Philp
13 Dr. Wesley J. Dunn
14 Dr. R. Marshall
15 Dr. John A. Pedler

16 DR. COUPLAND: Thank you, sir, My name is
17 Coupland, a dentist from Ottawa, Vice-President of the Royal
18 College of Dental Surgeons of the Province of Ontario.

19 First of all, Mr. Chairman and members of the
20 Medical Services Insurance Enquiry, I would like to thank you
21 and my colleagues of the Oral Surgeons, for deferring their
22 brief until the brief has been presented by the College at
23 large. We appreciate your consideration, sir, and theirs as
24 well.

25 I've been instructed, Mr. Chairman, on behalf
of President Bruce, the President of the College, which, as I
imagine you are all aware, is constituted of the 2,600 dentists



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of President Bruce, the President of the College, which, as I

imagine you are all aware, is constituted of the 2,000 dentists



1 who practise within the boundaries of Ontario ---

2 THE CHAIRMAN: Dr. Coupland, if I may interrupt,
3 it's quite in order for you to be seated, if you wish. On the
4 other hand, if you prefer to stand, please feel free to do so.

5 DR. COUPLAND: Sir, I believe you will hear me
6 better, and I promise to be brief.

7 Our President has particularly instructed me to
8 express the appreciation of our College for the opportunity
9 now provided to present the views of the College on the condi-
10 tions, some of the conditions that Bill 163, as it received
11 first reading -- we believe that in some of these provisions
12 are matters of vital interest to the future of the dental
13 services which the Ontario public will receive, and therein
14 lies our concern, and we most respectfully, and most earnestly,
15 solicit your favourable consideration of the observations which
16 are contained in the brief which you have received.

17 At this time, Mr. Chairman, may I introduce the
18 other delegates on this occasion? On my extreme left is Dr.
19 Philp, the President of the Ontario Dental Association; Dr.
20 Pedler is a member of the staff of the University of Toronto.
21 He is Professor of Oral Diagnosis, and he is also Dental
22 Surgeon-in-Chief of the Toronto General Hospital. On my
23 immediate right is Dr. Wesley Dunn, Secretary-Registrar of
24 the Royal College of Dental Surgeons of Ontario; and on his
25 right Dr. Robert Marshall, who is an oral surgeon, certified



1 who practise within the boundaries of Ontario --

2 THE CHAIRMAN: Dr. Gouglard, if I may interrupt,

3 it's quite in order for you to be seated, if you wish. On the

4 other hand, if you prefer to stand, please feel free to do so.

5 DR. GOUGLARD: Sir, I believe you will hear me

6 better, and I promise to be brief.

7 Our President has particularly instructed me to

8 express the appreciation of our College for the opportunity

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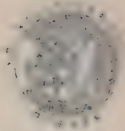
1 by the Province of Ontario, and also is the Chairman of the
2 Special Committee which prepared the brief which you have
3 received.

4 Now, with your permission, sir, I would like to
5 call on Dr. Dunn, who will summarize our brief and make some
6 observations on the proposals it contains.

7 DR. DUNN: Thank you, Mr. Chairman, for this
8 opportunity of very briefly pointing out the two basic
9 principles, really, which are contained in this joint presen-
10 tation from the Royal College of Dental Surgeons, our statutory
11 body, and the Ontario Dental Association, the voluntary organi-
12 zation of the dental profession in Ontario, because, in effect,
13 we have really made mention of two principles, and we feel
14 Bill 163 abrogates these principles, and we wish respectfully
15 to bring them to your attention.

16 First, the ability of any legally competent
17 practitioner to have the right to perform a service generally
18 regarded as a benefit within the statute, and we feel that
19 because the statute is definitive as far as physicians are
20 concerned, and the fact that the term "medical" seems to mean
21 the exclusive services of physicians, it denies the right,
22 ability and legal competency of members of many other profes-
23 sions to provide these services as well.

24 Explicit in The Dentistry Act of Ontario are
25 certain provisions for the treatment of oral structures by



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certain provisions for the treatment of oral secretions by



1 dentists, and The Medical Act provides, of course, an implied
2 consent for the members of the medical profession to treat any
3 part of the human body for which they feel competent. These
4 Acts are, therefore, overlapping. The list of services which
5 appears in the brief was not at all meant to be a definitive
6 outline of all services that could be rendered, but they were
7 simply to show that there is a list of services here which
8 does appear in the schedule of the Ontario Medical Association,
9 and yet dentists are competent to render these services.

10 We don't believe it is the intention of the
11 statute to eliminate the services from consideration, and we
12 don't suggest that.

13 The other principle which we would bring to
14 your attention is the matter of complete and full discussion
15 with the dental profession when its services form a part of an
16 enactment of this nature. The dental profession did make a
17 request at one time to be included, because of the fact that
18 we felt that a dentist could add significantly to the services
19 of this group, but we feel that when the services of another
20 profession are included in a statute of this nature it is
21 desirable to have as close co-operation as possible in any
22 plans which are designed to improve health.

23 We are specifically interested in dental health,
24 but you can't separate the two, and I can offer both for the
25 organization I represent and the Royal College of Dental



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1 Surgeons, all possible co-operation for this Enquiry, or any
2 other group which may be established to deal with the provi-
3 sions of this statute, and we, sir, would like to be included
4 in such discussions.

5 Those two principles are really the essence of
6 the presentation that we've made.

7 THE CHAIRMAN: Do you have any other delegates
8 who you wish to have speak?

9 DR. COUPLAND: No, sir.

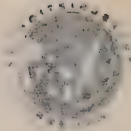
10 THE CHAIRMAN: Well, then, we'll hear from the
11 Ontario Society of Oral Surgeons, and then we will come back,
12 and we will ask questions of both at the same time.

13
14 SUBMISSION OF THE ONTARIO SOCIETY OF ORAL SURGEONS

15 Appearance: Dr. A.A. Antoni

16 DR. ANTONI: Mr. Chairman and members of the
17 Enquiry: as the Chairman stated, my name is Albert Antoni,
18 and I'm representing the Ontario Society of Oral Surgeons.
19 I was duly elected at one of the meetings, and given authority
20 to prepare a brief to deliver to this body.

21 Our brief is very short, but it is pointed. It's
22 intended to point out that certain forms of treatment which
23 must, of necessity, be included in any medical insurance plan,
24 are within the legal rights of dentistry, and are presently
25 being performed by dentists.



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1 That the present policy existent with some
2 insurance schemes of excluding dentists from receiving bene-
3 fits seems to be the policy included in Bill 163.

4 That this is discriminatory and unjust, both to
5 the public and to the dental profession.

6 That there is a very small, but highly-trained
7 and well-qualified, group within dentistry, known as oral
8 surgeons, who are very well-equipped, by virtue of their
9 training, to render, and, in fact, are rendering, many of the
10 services that are provided within Bill 163.

11 The brief elaborates on the training of an oral
12 surgeon, and outlines the scope of his activities. It quotes
13 The Dental Act of the Province of Ontario, to show that he is
14 completely within his legal rights to perform these services.
15 Indeed and surely his training does give him the moral right
16 to do so.

17 The brief also, and humbly, requests this
18 Commission to recommend, and to take definite steps to correct
19 this unfortunate situation that exists today by allowing it to
20 be perpetuated in Bill 163 as it presently reads.

21 Thanks very much, Mr. Chairman.

22 THE CHAIRMAN: Will the members of the Enquiry,
23 in asking questions, please direct the question to either Dr.
24 Coupland or to Dr. Antoni, and then if the question is
25 directed to you, Dr. Coupland and Dr. Antoni, and you wish

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Madea very much, Mr. Chairman.

THE CHAIRMAN: Will the members of the Industry,

directed to you, Dr. Goughland and Dr. Anton, and you wish



1 others to speak to the question, would you let the Chair know,
2 and vice versa?

3 Mrs. Aylen?

4 MRS. AYLEN: I would direct this question to Dr.
5 Coupland. Who is responsible for the relationship of the
6 dental profession to a public general hospital?

7 In other words, is there a pattern that you
8 can set up a department, or do you have to incorporate indivi-
9 dually?

10 DR. COUPLAND: Either of the gentlemen on my
11 right or left, I think, could provide a better answer than I
12 could.

13 DR. DUNN: Well, I'm not sure that I could
14 provide a better answer, Mrs. Aylen, but The Public Hospitals
15 Act, as I know you well know, at least, the amendment of
16 March, 1959, now makes it possible for a Board of Trustees of
17 a hospital to have created in that hospital a dental department,
18 or staff.

19 We have, for some time, been engaged in develo-
20 ping arrangements with appropriate groups in this regard, and
21 you may have noticed from the last report of the Canadian
22 Council on Hospital Accreditation that a significantly large
23 proportion has been added to the representation, making provi-
24 sion for a dental staff within a hospital, and suggesting
25 certain regulatory provisions which could be considered.

Mrs. Aylmer?

MRS. AYLMER: I would direct this question to Dr.

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1 Also, the Ontario Hospital Services Commission,
2 at the present time, has under consideration certain provisions
3 and regulations which will make the provision of dental
4 services within hospitals a little bit more practicable, or
5 perhaps a little bit more regularized than at the present time.

6 There are many hospitals in this jurisdiction
7 which have dental departments, and our Canadian Dental Associa-
8 tion is possessed of a Hospital Dental Services Committee,
9 which provides the service of approving the departments in
10 regard to certain standards. I would guess that the number
11 might be seven, eight or nine, and I think as time is moving
12 on regularization of dental services in hospitals is becoming
13 greatly clarified, and it is our opinion that there's adequate
14 statutory provision for such services today.

15 MRS. AYLEN: The second thing I would like to
16 ask is: does an oral surgeon practise dentistry, or does he
17 just simply -- is he always an oral surgeon?

18 DR. COUPLAND: To be certified a dentist must
19 restrict his practice to the specialty of oral surgery. He
20 can't retain his certification.

21 We're slightly different from medicine in this
22 regard. To enjoy certification one must limit himself to the
23 area in which he is certified.

24 MR. COULTER: Mr. Chairman and gentlemen, my
25 knowledge of dental surgery is rather limited, and I would like



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MR. COUTIER: Mr. Chairman and Gentlemen, my
knowledge of dental surgery is rather limited, and I would like



1 to know -- I think the first speaker said there were 2,600
2 dentists practising in Ontario.

3 If this is true, how many of these people would
4 be oral surgeons?

5 DR. COUPLAND: Approximately 40, sir.

6 MR. COULTER: And, for clarification on a point
7 that Mrs. Aylen raised, did I understand you correctly, a
8 person becomes a dentist, and then an oral surgeon? It's a
9 further qualification?

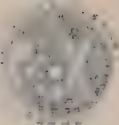
10 DR. COUPLAND: That's correct, yes.

11 MR. COULTER: And I think Dr. Antoni, somewhere
12 in page 3 of his brief, sub-section (d):

13 "We wish to make it clear that what we
14 are requesting will not lead to added
15 expenditure. On the contrary we believe
16 that it will mean a considerable saving,
17 since most of these operations when
18 performed by Oral Surgeons are on an
19 ambulatory basis."

20 Could I have this clarified a little further,
21 please?

22 DR. ANTONI: You can realize that what we are
23 requesting in our brief isn't that new services be added to
24 what will already be included as insurable in the Bill, or
25 indeed what is already included in most insurance schemes.



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ambulatory basis."

Could I have this clarified a little further,

DR. ANTON: You can realize that what we are



1 We're merely asking that those procedures which
2 we do as dentists, or oral surgeons, and are already included
3 in the brief, that we be recognized when we do them in the
4 same manner that the physician is at present.

5 MR. COULTER: One further question for my own
6 clarification, sir. I really don't know who to direct it to,
7 but, as I stated before, my knowledge is limited on this
8 subject.

9 I understand from the comments already stated
10 that a dentist isn't allowed, under your licence, to do oral
11 surgery; is this true?

12 DR. COUPLAND: No. I think Dr. Dunn has a
13 couple of observations that he wishes to make.

14 DR. DUNN: Mr. Chairman, under The Dentistry
15 Act of Ontario, a general practitioner in dentistry is
16 permitted to perform any procedure which he recognizes as
17 residing within his competence.

18 This is a principle which, presumably, applies
19 to other professions as well. Certainly, it is pertinent to
20 medicine, but we do have an additional group who have become
21 specialists, following three years' study, subsequent to
22 graduation from an approved dental faculty; one year in basic
23 sciences, two in approved oral surgery internship programs in
24 hospitals, and after this three-year period then the certified
25 oral surgeon naturally will proceed to do much more complicated



1 surgical procedures than will the general practising dentist.

2 We have about 40 oral surgeons in the entire
3 province, and I presume that over half of them reside within
4 Metropolitan Toronto. Therefore, there are areas which
5 perhaps aren't sort of too adequately -- and we have many
6 general practitioners who are quite competent to do at least
7 some of these oral surgical services when called upon to do so.

8 MR. COULTER: This is one thing that was
9 bothering me. When you said 40, the Province of Ontario is a
10 large place, and I'm rather surprised to hear that approxi-
11 mately half of them are residents of the metropolitan area of
12 Toronto.

13 I was wondering how the people in the rest of
14 Ontario get the service of an oral surgeon, or is it available
15 to them, or is it done by someone else, probably not qualified?

16 This is what I'm trying to get at.

17 DR. ANTONI: The practice of oral surgery, as
18 it's carried on today, is strictly an oral practice on patients
19 referred by dentists or physicians, and in our own group we
20 have patients brought down from North Bay, Timmins, from every
21 corner of the province, and I'd imagine that it's the same
22 with every one of us who practises oral surgery.

23 THE CHAIRMAN: Dr. Galloway?

24 DR. GALLOWAY: Thank you, Mr. Chairman. I also
25 would request some clarification because of my ignorance of the

surgical procedures than with the general practicing dentist. We have about 40 oral surgeons in the entire province, and I presume that over half of them reside within Metropolitan Toronto. Therefore, there are areas which perhaps aren't sort of too adequately -- and we have many general practitioners who are quite competent to do at least some of these oral surgical services when called upon to do so.

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DR. CALLOWAY: Thank you, Mr. Chairman. I also would request some clarification because of my ignorance of the



1 activities in some regards of the dental profession.

2 I'm not sure exactly the place of the Royal
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4 College of Physicians and Surgeons of Canada, who are entitled
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6 Do I gather it's the Royal College of Dental
7 Surgeons who are the licensing body for all dentists in
8 Ontario?

9 DR. COUPLAND: That's correct, sir. As yet
10 the certification of specialists has remained a provincial
11 prerogative in dentistry. We have being drafted at the
12 present time, and probably almost as far advanced as this
13 Bill you are considering, a Bill creating a Royal College of
14 Dentistry in Canada, which we hope will enable us to take over
15 the national granting of fellowships, and doing certification,
16 as the Royal College of Physicians and Surgeons possibly for
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19 DR. GALLOWAY: Who actually gives a man a
20 licence to practise dentistry in Ontario?

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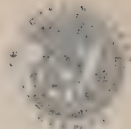
5 DR. COUPLAND: An assessment of their training,
6 and consultation with the specialty group, which is represented
7 here.

8 DR. GALLOWAY: There's no actual examination of
9 a man's ability practically, or in any other way?

10 DR. COUPLAND: Well, I would like to have Dr.
11 Dunn help me out on that.

12 DR. DUNN: The examination is somewhat akin to
13 the examination procedure for the actual registration and
14 licensing of dentists in the Province of Ontario, where, in
15 effect, the graduate of the Faculty of Dentistry of the
16 University of Toronto, when he successfully completes his
17 final examination of this faculty is deemed to have passed
18 the voluntary licensing examination of the Royal College of
19 Dental Surgeons of Ontario.

20 In a similar way the examination of those
21 seeking certification in a specialty in Ontario is done.
22 That is, the man must complete a written examination of his
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2 authorities at the hospital at which the internship was taken,
3 or the internships were taken, the appropriate documentation
4 to attest to the fact that he has fulfilled the requirements
5 of that institution for his service, and on the assessment of
6 that the certification in the specialty is determined.

7 DR. GALLOWAY: You spoke of approved hospitals,
8 and it is spoken of in Dr. Antoni's brief.

9 Who is the approving body, and how many approved
10 hospitals are there in Ontario?

11 DR. DUNN: I'm not sure I can answer the second
12 part of your question with exactness, but the Canadian Dental
13 Association acts on our behalf in terms of the assessment of
14 dental institutions of learning, and we have in the Canadian
15 dental profession a relationship with our American colleagues,
16 so that those schools in the United States which have been
17 approved by the Council on Dental Education of the American
18 Dental Association are automatically approved in Canada, and
19 the reverse is also true.

20 Our Council on Education has established a
21 Survey Committee, which has established and had approved by
22 the Board of Governors of our national organization, minimum
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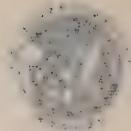


1 As far as the specialty groups are concerned,
2 we have to deal with them more on an individual basis, and
3 each program is virtually assessed on its own, and in the
4 Royal College of Dental Surgeons of Ontario we have a committee,
5 the Committee on Registration and Licensure, and it is this
6 committee which has the responsibility for determining whether
7 these institutions meet acceptable standards or not.

8 DR. GALLOWAY: The term "oral surgery" is, as
9 frequently used by physicians and surgeons, for those physi-
10 cians and surgeons who are performing these operations. Am I
11 correct in assuming, then, that there are three different
12 groups of people performing oral surgery? One would be a
13 surgeon with some special degree of training in surgery around
14 the head and neck and mouth; secondly, a group of surgeons,
15 medically-trained, and, as well, dentally-trained; and, finally,
16 a group of dentists who have, by virtue of special training,
17 become specialists in dental oral surgery.

18 Do all three of these groups belong to the
19 Dental Oral Surgeons' Association?

20 DR. ANTONI: In the profession of dentistry
21 oral surgery is a recognized specialty. It is the oldest
22 specialty that we have in the profession of dentistry. When
23 it was actually instituted as a specialty, I just don't
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1 All dental schools -- possibly I shouldn't say
2 all -- but almost all, to my knowledge, have Departments of
3 Oral Surgery. Many dental schools have graduate programs in
4 oral surgery. I know of no medical school anywhere that has
5 an oral surgery program, either in the undergraduate level or
6 in the graduate level.

7 The only literature, the only journals of oral
8 surgery that I'm aware of are under the aegis of dentistry.
9 So, as far as we are concerned in dentistry, oral surgery is
10 an integral part of dentistry. It has always been, and we
11 have always nourished and nurtured it.

12 DR. GALLOWAY: This doesn't, however, preclude
13 the fact that there are surgeons doing the same kind of work?

14 DR. ANTONI: No, sir. There are surgeons who
15 do certain phases of oral surgery. In all phases, the greater
16 part of oral surgery has to do intimately with the teeth, the
17 field of very difficult impacted teeth, very difficult extrac-
18 tion, preparing some teeth so that the orthodontist could move
19 them into a proper position to prevent malocclusion, and
20 several other services of that essential nature, which have
21 nothing to do but with the teeth themselves. There are
22 general surgeons, orthopaedic surgeons, plastic surgeons, who
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24 DR. GALLOWAY: Would extractions form a very
25 major part of the work of an oral surgeon?

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1 DR. ANTONI: Yes, sir, it does form a very major
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3 DR. GALLOWAY: There are some men, are there
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5 as oral surgeons?

6 DR. ANTONI: There are some men who do nothing
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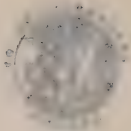
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11 a minimum of training requirements of three years, and these
12 men are now certified as oral surgeons, and they are the
13 people who limit themselves to the surgical aspect of dentistry,
14 which includes the extraction of teeth.

15 A dentist can't just announce himself as a
16 specialist in oral surgery without meeting these requirements.

17 DR. GALLOWAY: Would you, then, if this plan
18 was carried through the various insurance plans, anticipate
19 bills from all dentists or just oral surgeons, for the extrac-
20 tion of teeth?

4 21 DR. COUPLAND: We would have to insist that
22 properly it should include all qualified dentists, and not be
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1 the brief that the R.C.D.S. is presenting, they aren't reques-
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3 DR. MARSHALL: There was one point, Mr. Chair-
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5 and I felt that the answer wasn't complete.

6 He asked if there are some dentists who do
7 limit their practice to the extraction of teeth, who aren't
8 oral surgeons, and the answer is yes. There are. There aren't
9 many, but there are some people who do limit their practice
10 to this field who aren't certified.

11 DR. GALLOWAY: Would you consider that the
12 extraction of teeth is among the more minor aspects of an
13 oral surgeon's work?

14 DR. ANTONI: The complicated extraction, yes,
15 but there are some dental extractions that can be complicated,
16 and very, very difficult.

17 DR. GALLOWAY: Would you consider among the
18 more advanced procedures that these insurance companies could
19 expect bills for -- how far do you go, in other words?

20 DR. DUNN: Again, I'm not sure that I should be
21 the one that is answering it, but I think the principle that
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1 should accept an account from the dentist as well.

2 We're not suggesting any new services beyond
3 which would already be included, and on pages 5 and 6 of our
4 brief are certain procedures which, presumably, are performed
5 by physicians and these appear in the schedule of the Ontario
6 Medical Association. There are also services here which
7 reside within the competence of dentists.

8 DR. GALLOWAY: I would like to carry this one
9 step further, then. In this Bill it is commented upon, the
10 way it is at present written, that the fees that will be paid
11 will be based on the schedule of the Ontario Medical Associa-
12 tion.

13 Do you have a similar set of fees?

14 DR. DUNN: The Ontario Dental Association, as
15 our voluntary agency, does have a similar set of fees, but
16 not developed in the detail in which the Tariff Booklet of the
17 Ontario Medical Association is developed.

18 It is interesting that at the present time
19 there is a Committee of Revision dealing with this document,
20 because it's recognized that perhaps it isn't sufficiently
21 inclusive to deal with some of these concerns.

22 The Ontario Society of Oral Surgeons, because
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1 The answer, to summarize, is yes, there is a
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4 sion of this province.

5 DR. GALLOWAY: I noticed in these lists that
6 you've presented, there's no comment about the statement of
7 fees, and do I take it from your desire to be included in the
8 benefits the patient would receive that it would be on the
9 basis of the Ontario Medical Association's fees you are tying
10 your fees?

11 DR. DUNN: I'm not sure that it would be valid
12 to make that conclusion. I think I get back now to the second
13 principle which I attempted to enunciate: that is the principle
14 of consultation between the profession and any agency developing
15 the arrangement, because I think it must be pointed out that
16 the vast majority of oral surgical procedures are performed
17 for ambulatory patients in the individually-maintained esta-
18 blishment of the oral surgeon, whereas there are many other
19 fees which are established for surgical services predicated
20 upon the services being rendered in the public general hospital.

21 Therefore, there are certain cost factors in
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2 "Yes, we would provide services on this schedule of fees,"
3 because there are different circumstances which may apply.

4 DR. GALLOWAY: In some of the briefs which we
5 have already had presented to us, it has been suggested that
6 the Ontario Medical Welfare Plan should continue to look after
7 the indigent patients in the province, and at the present time
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9 and surgical procedures as they may perform on a pro-rated
10 basis.

11 Does your Association have any similar sort of
12 arrangement for indigents, and if you came in on such a plan,
13 and pro-ration were part of it, would your Association be
14 willing to accept the pro-rated accounts?

15 DR. DUNN: The dental profession in Ontario
16 administers, under its own aegis, a dental welfare plan, which
17 applies to but one of the groups covered under the Ontario
18 Medical Welfare Plan.

19 Our profession provides what we call basic
20 dental care services to children under 18 years of age who
21 qualify within the meaning of the Mothers' Allowance of the
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3 Our contract with the Department of Public
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7 of a pro-rated fee at the present time.

8 This has varied, just as the Ontario Medical
9 Welfare Plan has varied. At the present time, the pro-ration
10 factor is 66.2/3%, so that the dentist does receive two-thirds
11 of the normal fee which would apply to one of the authorized
12 services to one of these beneficiaries.

13 But we have just the children's group, and,
14 largely speaking, these services don't reside within the
15 concept of Bill 163.

pw 16 DR. HAMILTON: Have you given any thought at
17 all as to the re-wording of this so that we would understand
18 what you wished to exclude in dental services, because it
19 would seem to me that the way this is progressing, from your
20 discussion this afternoon, that it would be very easy for
21 this plan to take over all of dentistry on an insurance basis,
22 and I am not too sure, from what I know of your Association,
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13 solicitor's viewpoint in terms of our profession. But if I
14 might just introduce the subject, we believe that there would
15 have to be modest amendments in at least three areas. In
16 Section 1(1) of this statute, on page 2, reference is given
17 to "under the direction of a physician." We would suggest,
18 with respect, that this could have an additional phrase,
19 "under the direction of a physician or, where applicable,
20 under the direction of a dentist."

21 Then, following sub-section (1) where the word
22 "physician" is defined, we would suggest that very similar
23 wording could be employed for "dentist," reading "'dentist'
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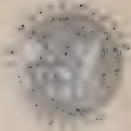


1 jurisdiction outside Ontario in which medical or surgical care
2 or services are rendered to a resident."

3 Then the others would be re-lettered accor-
4 dingly. Then the third and final area that we feel could
5 receive some attention would be Schedule A, under 3, where
6 exceptions are given and rather than the words "dental
7 services" as accepted at the moment, we might have words
8 something of this order: "services recognized as being exclu-
9 sively dental in character; for example, tooth restorations,
10 including endodontic services, prostheses, orthodontic
11 services, extractions and adjunctive procedures, periodontal
12 services and radiographic and anaesthetic services rela-
13 ting to the foregoing." We feel that this would provide an
14 adequate protection which I believe the authors of Bill 163
15 were concerned about when there was a blanket exception given
16 to dental services, and this, then, would permit the legally
17 competent dentist to perform the non-excluded services for
18 which the Bill makes provision.

19 Then, if it is something that would be of value
20 to you, I think we would be very pleased to give this more
21 thought than obviously a few non-legal minds have given this
22 and provide you with what we believe would be a proper amend-
23 ment to this statute as it now exists.

24 THE CHAIRMAN: We would be pleased to have that,
25 I am sure.



or services are rendered to a resident."

Then the others would be re-lettered accordingly.

Then the third and final area that we feel could

receive some attention would be Schedule A, under 3, where

exceptions are given and rather than the words "dental

services" as accepted at the moment, we might have words

something of this order: "services recognized as being exclu-

sively dental in character; for example, tooth restorations,

services, extractions and adjunctive procedures, periodontal

procedures, and so forth."

thing to the foregoing." We feel that this would provide an

adequate protection which I believe the authors of Bill 163

were concerned about when there was a blanket exception given

to dental services, and this, then, would permit the legally

competent dentist to perform the non-excluded services for

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ment to this statute as it now exists.

THE CHAIRMAN: We would be pleased to have that.



1 DR. DUNN: That will be provided.

2 DR. HAMILTON: I am still not clear on the work
3 of the dental oral surgeon and I am trying to get it clarified.
4 Would it be possible to put it this way, as you did not want
5 to tell me what were your minimum and maximum things that you
6 do, that the work of the oral surgeon is intra-oral work?

7 DR. ANTONI: No. I can't say that we can say
8 that at all. Sometimes it is necessary to remove a tooth
9 through an extra-oral approach, so we cannot be limited to
10 strictly within the limits of the mouth. We cannot reduce a
11 fractured jaw, in a lot of instances, strictly from an intra-
12 oral approach; it has to be through an extra-oral approach.

13 You cannot let pus out from a severe abscess,
14 in a lot of instances, only through the mouth. It has to be
15 done extra-orally. So that we cannot say that you can limit
16 the scope of oral surgery only to intra-oral procedures.
17 I think in our brief, on page 2, we define this. There is a
18 heading, under Section 4: "What is an oral surgeon?" It says:

19 "There are, among the members of the dental
20 profession, certain individuals who limit
21 their practices to the surgical treatment
22 of diseases, injuries and malformations
23 of the human teeth, jaws and their asso-
24 ciated structures. Included in this area
25 of treatment are such conditions as



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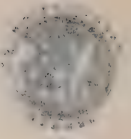
1 difficult dental extractions, dental impac-
2 tions, dental infections, exostoses and
3 osteomas of the jaws, fractures of the jaw
4 bones, cysts of the jaws and soft tissue of
5 the oral cavity, benign neoplasms of the
6 jaws and oral cavity, jaw deformities,
7 maxillary antral involvement of dental
8 origin and oro-antral fistulae. Dentists
9 performing this range of treatment selectively
10 are known as oral surgeons."

11 DR. HAMILTON: I think that has helped clarify
12 it. What would you do with the case of a carotid gland in
13 which stones had formed, some of which might be in the ducts
14 or some in the gland?

15 DR. ANTONI: I can only give you my personal
16 opinion on that, Mr. Chairman. I think a carotid gland tumor
17 is a job for, in my opinion, a general surgeon.

18 DR. HAMILTON: The other questions have to do
19 with insurance only and I can give them to you both at once.
20 Are your services, at the present time, being covered by any
21 of the insurance carriers and are they being carried on more
22 or less basic plans or extended health services?

23 DR. MARSHALL: Inasmuch as this question was
24 asked this morning when we were present, of another group, we
25 did note some of the companies which do and have in the past



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did note some of the companies which do and have in the past



1 insured some of these services, insofar as dentists are
2 concerned. This is not all-inclusive, by any means, but
3 London Life, Aetna Life, Great West Life, Mutual of Omaha,
4 Travelers', Zurich, Occidental Life and Metropolitan Life are
5 some of them.

6 DR. HAMILTON: Thank you.

7 DR. ANTONI: Have you got Commercial, too?

8 DR. HAMILTON: Is it under a more basic plan
9 or is it on an extended health services? For example, it is
10 possible that P.S.I. has a physicians' services agreement
11 and then they have a rider for a greater amount of insurance
12 in which they cover some dental surgery, some nursing and
13 things of this nature.

14 DR. MARSHALL: Some of these are covered under
15 a basic plan and some of them are extended plans.

16 DR. HAMILTON: My final question is: is it
17 your intent or request or even so far as demand, if we
18 proceeded with this Act to make a basic medical plan, that
19 you wish this service to be included in the basic medical
20 plan or would you be happier if it was insured under extended
21 health benefits by carriers?

22 DR. DUNN: I think we get back to the definition
23 of the word "medical." If we mean by "medical" the provision
24 of health care services by legally competent practitioners,
2 25 I would hope that dental services or services which reside

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1 within the academic and legal competence of both professions
2 would be included in a basic plan. It may be that subsequent
3 to this, or that further thought will be given to extended
4 benefits which will then include services which I think
5 people will regard as more or less exclusively dental in
6 character; but where there is an overlapping of professional
7 responsibility and consideration, we believe that those
8 services should reside within the basic program.

9 DR. HAMILTON: I apologize, Mr. Chairman, if I
10 have taken more than my share of time. I hope that it has
11 been of some value to the Enquiry.

12 MR. SIMON: Dr. Dunn, has your Association got
13 any statistics as to the per capita costs for dental care in
14 Ontario?

15 DR. DUNN: I am not sure that I can quote...

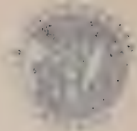
16 THE CHAIRMAN: Pardon me, Mr. Simon. Do you
17 mean dental care in general?

18 MR. SIMON: Yes.

19 THE CHAIRMAN: All dental care?

20 MR. SIMON: Yes.

21 DR. DUNN: We have figures that were supplied
22 to the Royal Commission on Health Services and I think it can
23 be calculated that approximately \$42 million are expended every
24 year in Ontario on dental health services. This amount
25 includes not only the service provided by private practitioners,



people will regard as more or less exclusively dental in character; but where there is an overlapping of professional responsibility and consideration, we believe that these services should reside within the basic program.

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MR. SIMON: Yes.

THE CHAIRMAN: All dental care?

MR. SIMON: Yes.

DR. DUNN: We have figures that were supplied to the Royal Commission on Health Services and I think it can be calculated that approximately \$26 million are expended every



1 but I presume as well that it includes service provided in
2 some forms of institutions by salaried personnel. But we can
3 also state that approximately 35% of our population only seeks
4 active dental care in any one year and of that 35% we really
5 have no way of measuring those who seek an emergency service
6 and those who desire more or less complete care. This figure
7 is somewhat conjectural. But the \$42 million to which we make
8 reference really applies to the 35% of the population in any
9 one year.

10 MR. SIMON: Those few insurance companies that
11 cover dental care, proportionately, who decides the fees for
12 the dentist for the service rendered; is that decided by the
13 Association or by the dentists themselves, or the insurance
14 companies? How do you arrive at the fee?

15 DR. MARSHALL: This has been decided by some
16 degree of consultation and, in many cases, the stipulated
17 fee schedule is included in the terms of the individual policy.

18 MR. SIMON: My next question relates to the
19 one that Dr. Dunn just answered a couple of seconds ago. If
20 35% of the population take advantage of the dental care yearly,
21 has your organization given any thought to the promotion of
22 any plans for dental care, the same as the physicians have
23 to P.S.I., and so on?

24 DR. DUNN: Yes, sir. There has been a signi-
25 ficant amount of work performed by the Dental Services

DR. DUNN: Yes, sir. There has been a signif-

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some forms of institutions or salaried personnel. But we can



1 Committee of the Royal College of Dental Surgeons on this
2 subject and I would suspect that there will be smiles on the
3 faces of a few people at the table when I say that this
4 subject is possessed of overwhelming complexity. One of the
5 great problems of providing dental care services is that it
6 is something that some of us question is actually insurable
7 because I think, as I can look around this room, one can
8 pretty well guarantee that, with perhaps one or two exceptions,
9 everyone here, perhaps, could do with some form of elective
10 service and it is an extremely difficult thing to insure
11 against conditions which affect virtually all the adult popula-
12 tion or, in fact, all the population past infancy.

13 This is one of the real perplexing problems
14 which is engaging our concern. We have made initial attempts
15 to seek information through the office of the Superintendent
16 of Insurance to determine what requirements would have to be
17 met in order to establish a dental services organization,
18 patterned somewhat on Physicians' Services Incorporated, and
19 I am afraid our studies have not yet advanced to the place
20 where we are able to proceed. But it has not been for want
21 of trying.

22 MR. SIMON: One more question. In the perfor-
23 mance of your oral surgery, do you have cases where physicians
24 refer patients to the oral surgeons?

25 DR. ANTONI: Yes, sir, in very many instances.

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1 MR. SIMON: There are some?

2 DR. ANTONI: Yes.

3 THE CHAIRMAN: Mr. Whitney?

4 MR. WHITNEY: Mr. Simon asked for some costs,
5 generally. The next question is: have you any estimate,
6 generally, as to what the oral surgery care is costing at the
7 moment, per annum?

8 DR. MARSHALL: There is one reference to this
9 in our brief and I am sure you are aware of this. There have
10 been no estimates made in this province, but in the one
11 article referred to in our brief, it was estimated in the
12 Greater Utica area that the cost per year per participant was
13 10 cents for all oral surgical procedures.

14 MR. WHITNEY: That is the whole population
15 paying 10 cents each?

16 DR. MARSHALL: That is correct - per participant.
17 This is only the participants of the Utica plan.

18 DR. HAMILTON: There is one question. This is
19 probably asking you to repeat something. I do not think the
20 brief is clear. In the brief of the Royal College of Dental
21 Surgeons, are you asking that the coverage by insurance
22 shall include oral surgery only?

23 DR. DUNN: No, sir. I do not think that would
24 be the precise interpretation.

25 DR. HAMILTON: That is not your interpretation?

THE CHAIRMAN: Mr. Whitby?

MR. WHITBY: Mr. Dixon asked for some costs.

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generally, as to what the oral surgery care is costing at the

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be the precise interpretation.

DR. HAMILTON: That is not your interpretation?



1 DR. DUNN: That is not the interpretation.

2 DR. HAMILTON: Then are you asking that certain
3 procedures that may be done by an oral surgeon, or by a
4 dentist, may be covered?

5 DR. DUNN: Well, sir, I do not think that is
6 the interpretation.

7 DR. HAMILTON: Will you tell me, then?

8 DR. DUNN: Yes. What the brief says, going
9 back to the first principle, are these services which Bill 163
10 encompasses, under the jurisdiction, if you like, of the
11 physician; or, to put it another way, if remuneration will
12 be paid for a physician for a particular service which
13 resides within the competence of the dentist, then the dentist
14 should participate equally.

15 DR. HAMILTON: This is very broad and exactly
16 what I am trying to get at. Can you define this more clearly?

17 DR. DUNN: It can certainly be defined more
18 clearly, but not precisely. For instance, with the suggestion
19 I made a few moments ago about excluding certain services
20 which were exclusively dental in character, such as extractions,
21 this forms a large portion of the services of an oral surgeon;
22 but a fractured maxilla or fractured mandible also resides
23 within their competence and would be covered, presumably.

24 DR. HAMILTON: Can you provide that list of
25 things that should be covered within the terms of your brief?

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2 DR. HAMILTON: I am sorry to insist on clarity
3 of what you mean, but when you are not asking that dental
4 services be insured, but only certain services that may be
5 rendered by a dentist, whether he be a dental specialist or
6 not, I think it is extremely important that the Enquiry is
7 fully aware of the extent and limitations of what you are
8 asking and I would, therefore, Mr. Chairman, ask that if
9 possible Dr. Dunn would submit a list of the procedures or
10 conditions which, in his opinion, should be covered under
11 this.

12 THE CHAIRMAN: Would you be willing to do that?

13 DR. DUNN: Yes, sir. I do not want to appear
14 to be intractable here, but there is another principle involved.

15 DR. HAMILTON: It is entirely voluntary?

16 DR. DUNN: Yes. I think we can do it, except
17 for the fact I wouldn't want anyone to infer from this list
18 that there is an automatic exclusion of any other procedure
19 which may subsequently reside within the competence of such an
20 individual to perform. In other words, I think there is an
21 overriding professional responsibility on any health worker
22 to provide those services which he can show he has been
23 trained to perform and I do not think such limitations would
24 be asked of our medical colleagues and while we would be
25 prepared to provide such a list, I wouldn't want to assume that

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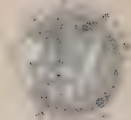


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2 applied in 1963. This is a minor point, perhaps, but pretty
3 major with us.

4 THE CHAIRMAN: Mr. Whitney?

5 MR. WHITNEY: I would like to point out some-
6 thing here. I am very interested in the question the Dean
7 has put to you. I have been thinking about it from the
8 practical view of legislation. You made certain suggestions
9 about amendments to the three sections of the Act. It would
10 strike me rather that it might be a lot easier in considering
11 the services that you want covered if we did have such a list
12 and possibly look forward to thinking in terms of putting
13 something of that nature in regulations.

14 The regulations could be written in such a way
15 that it would give you the protection that you just asked for
16 in submitting the list. I do not agree that the situation is
17 parallel with the medical profession, because here you have
18 a sweeping situation where you want to distinguish between
19 covered services and some services that you do not want
20 covered. So we have to find a division here somewhere and
21 I do not want you to think in terms of having a long list of
22 things in the Bill. We have an overriding power in the Bill
23 to pass regulations and it might be that the proper mechanism
24 to use there is to put some general reference in the Bill to
25 cover certain services, such as may be approved by regulation,



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2 this regulation is a regulation that is not necessarily a
3 final regulation; that if new things turn up, new services
4 are required of the oral surgeon, that it is easy to change
5 a regulation. It is difficult to change a statute. Do you
6 follow me?

7 DR. DUNN: Yes, sir.

8 MR. WHITNEY: I am saying these things so that
9 when you talk to your lawyer - and I am of that profession -
10 if you talk to him along these lines, there is more than one
11 way of skinning a cat, in drafting these things, and I think
12 that probably the regulation method might satisfy Dean Hamil-
13 ton's problem, and I think this is a real problem.

14 DR. DUNN: I think I could agree with you. But
15 here again, I am at a disadvantage. I am not a lawyer and it
16 seems to me that in order for a regulation to apply to a
17 professional group which is not already authorized to provide
18 a service within a statute, we are on rather weak ground. In
19 other words, if provision can be made for services under the
20 direction of a dentist, where applicable, and if a definition
21 of "dentist" were provided in the statute, then I think we
22 could agree that in general regulations we could probably
23 handle the problem that has just been brought up.

24 MR. WHITNEY: We are not at cross purposes
25 here. I do not suggest that we not amend the statute. I



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22 could agree that in general regulations we could probably
23 handle the problem that has just been brought up.

24 MR. WHITNEY: We are not at cross purposes

25 I do not suggest that we not amend the statute.



1 suggest that some recognition is a possible consideration of
2 this Committee as to oral surgery generally in the statute,
3 and then some cross-reference as to the services covered,
4 and work out a regulation. This regulation can be worked out
5 in consultation with your group. Then we would have a picture
6 which we could, when we get to the question of recommendations,
7 or tallying up our submissions, get in more or less a concrete
8 form for those who are going to determine higher policy.

9 THE CHAIRMAN: I do not wish to take the floor
10 away from you, Mr. Whitney.

11 DR. HAMILTON: I have no further questions.

12 THE CHAIRMAN: Are there any further questions?

13 DR. BUTT: In the brief, on page 8, you include
14 facial injuries as part of the - I believe this is what you
15 are inferring - as part of the oral surgeon's work; is this
16 correct? This really follows up the reason we are asking, to
17 a certain degree, what was meant. Is this true, that this is
18 what you feel is part of the oral surgeon's work?

19 DR. MARSHALL: This is a direct quotation.

20 DR. BUTT: I realize this. You have also
21 quoted, if I am correct here, the Wisconsin legislation,
22 Illinois, New York and so on?

23 DR. MARSHALL: Yes.

24 DR. BUTT: And this, I presume, is an analogous
25 situation. What you are asking, I believe - and you correct me



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suggest that some recognition is a possible consideration of
this Committee as to oral surgery generally in the statute,
and then some cross-reference as to the services covered,
and work out a regulation. This regulation can be worked out
in consultation with your group. Then we would have a picture
which we could, when we get to the question of recommendations,
or tallying up our submissions, get in more or less a concrete
form for those who are going to determine higher policy.

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DR. BUTT: And this, I presume, is an analogous

situation. What you are asking, I believe - and you correct me



1 if I am wrong - is that we adjust the legislation to agree with
2 their interpretation?

3 DR. MARSHALL: Not at all. I am sorry if this
4 inference is here.

5 DR. BUTT: Isn't that inference in the brief?

6 DR. MARSHALL: Perhaps I can clarify this by
7 saying that in many instances, in a case of maxilla facial
8 injury, oral surgeons work in conjunction with medical-surgical
9 specialists in hospital, at the same time, on these patients.
10 It is not our wish to expand the scope of oral surgery through
11 the presentation of this brief, if that is what you mean.

12 DR. BUTT: You mentioned earlier something about
13 possible regulations in some form or other and you wanted some-
14 thing like incisions of cysts and tumors of the oral cavity.
15 Now, literally, this means carcinoma of the tongue, carotid
16 tumors. You will have to be specific if you say it is not
17 because you are asking for this to be a hospital bylaw.

18 DR. DUNN: This point has been, I think, effec-
19 tively covered with the Committee of the Ontario Hospital
20 Services Commission, the O.H.A., the O.M.A. and the Ontario
21 Department of Health, in dealing with that and we were queried
22 on this point because it comes from a statement from a series
23 of reports which appear in a booklet produced by our Hospital
24 Dental Services Committee and the assurance was given at that
25 time that we were dealing with benign tumors of the oral



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6 DR. MARSHALL: Perhaps I can clarify this by

7 saying that in many instances, in a case of maxilla fracture

8 the maxilla is fractured in such a way that the

9 operation is required to be done in such a way that

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22 on this point because it comes from a statement from a series

23 of reports which appear in a booklet produced by our Hospital

24 Dental Services Committee and the assurance was given at that

25 time that we were dealing with benign tumors of the oral



1 cavity and, presumably, the people involved in drafting these
2 provisions will take that into account. We recognize there
3 is an area of misinterpretation on that point, which we hope
4 we have cleared with the group dealing with regulations.

5 DR. BUTT: For the purposes of the Bill you
6 have to either define physician or dentist and you have given
7 your explanation of a physician there. How do you define
8 such things as cleft palate and cleft lip, and so on? Are
9 these within or without your scope?

4 10 DR. ANTONI: In certain areas of the United
11 States, for instance, the oral surgeons are definitely the
12 most competent people to deal with the problem of cleft lip
13 and palate. In very many areas the problem of cleft lip and
14 palate is dealt with on a team basis and in those teams the
15 team will not be complete if it does not include dentists,
16 general dentists, oral dentists, oral surgeons. There is
17 scope for everyone in the rehabilitation of a cleft lip and
18 palate case.

19 Indeed, the plastic surgeon, the ear, nose and
20 throat surgeon, the paediatrician, and so forth, will also
21 play a very important role. I do not think that the oral
22 surgeons infer that they are going to take over the management
23 of cleft lip and palate rehabilitation. I think this is one
24 field where we can, with consultation, achieve what is best
25 for the patient's interest. There are some oral surgeons who



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1 are very well trained in this field. In Ontario, unfortunately,
2 we do not have any such provision for the training of oral
3 surgeons in cleft lip and palate surgery.

4 DR. BUTT: But with regard to the Bill, how do
5 you feel about it? There are certain areas in the United
6 States where this is done, you say; but then we also have
7 your provision in your statement that there is certain legis-
8 lation or analogous legislation. Now, I understand that you
9 do not wish this analogous legislation. Now, coming specifi-
10 cally to our Bill here, what do you want?

11 DR. ANTONI: I did not understand that Bill 163
12 was designed to regulate the activities of...

13 DR. BUTT: No. I am merely asking you what you
14 wish.

15 DR. ANTONI: I think that if we have an oral
16 surgeon who is very well trained in the field of cleft lip
17 and palate rehabilitation and within the local environment of
18 the hospital in which he operated and within the regulations
19 that governed that hospital, if he was given the privilege of
20 working on these patients, through the people who would be
21 responsible for handing out those privileges, then I think
22 that the Bill should so recognize it. Yes.

23 MR. WHITNEY: Is that an in-hospital treatment
24 you are talking about?

25 DR. DUNN: At the Toronto Hospital for Sick



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1 Children, there is a cleft lip and cleft palate treatment and
2 research centre, the structure of which is predicated on a
3 team approach, to attempt to bring the talents of the various
4 disciplines to bear on the child who has this unfortunate
5 problem: a physician, a surgeon, an orthodontist, almost all
6 the time a speech therapist, a social worker, and other people
7 involved in this problem, and I do not believe that you can
8 segregate the treatment of a youngster with cleft lip and
9 palate into departments. And I believe that this gives the
10 best results. I have said in the brief, and Dr. Cox of the
11 Hospital for Sick Children would bear this out, that this is
12 done in other countries where there is a team approach to the
13 problem of such disfiguration as this one, and this is what
14 should be included.

15 And I would like to hope that the general
16 regulations we were talking about would permit an all-inclusive
17 treatment when we have a problem of this complexity.

18 DR. BUTT: You mentioned certain hospitals where
19 they are trained. What ones are there in Ontario, or is it
20 in the United States, and, if so, which ones there?

21 DR. ANTONI: I will answer this this way: most
22 of the oral surgeons that we have practising, not only in
23 Ontario but in Canada today, the majority are American-trained
24 men and we did not have a formal course as we have outlined
25 here earlier until 1953 and that course has been slowly

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1 developed to this stage, where it has progressed very satis-
2 factorily. The only course that I know of in Ontario is given
3 under the Faculty of Dentistry of the University of Toronto.
4 The basic science for that is done at the University of Toronto
5 and the two clinical years are then done at the Toronto General
6 Hospital and Doctors' Hospital has also been approved as an
7 internship year in oral surgery.

8 DR. BUTT: There are many of them in the United
9 States?

10 DR. ANTONI: There are several in the United
11 States, yes. The American Society of Oral Surgeons is made up
12 of 1,200 members. There are 1,200 practising oral surgeons in
13 the United States.

14 THE CHAIRMAN: You are finished, Dr. Butt?

15 DR. BUTT: Yes.

16 THE CHAIRMAN: Any further questions? Do you
17 have any further comments?

18 DR. PHILP: I would like, on behalf of the
19 Ontario Dental Association, to express our thanks and apprecia-
20 tion for the privilege of being here today and meeting with you
21 and presenting our views in regard to these hearings. Thank
22 you.

23 THE CHAIRMAN: Thank you. We are pleased to
24 have you here.

25 DR. J.H. JOHNSON: I would like to re-emphasize

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1 that there is no intention of any extension of services in
2 the purpose of our presenting the brief. We are only asking
3 that coverage be given that has already been given and we
4 certainly are not intending to channel people into any parti-
5 cular group. But we wish that the public would have complete
6 freedom of choice and I think that the public will have the
7 intelligence to go wherever they think they will get the best
8 services.

9 There is one facet that was not mentioned and
10 this has a tremendous impact from the standpoint of teaching.
11 If the Government should set up under Bill 163, where these
12 borderline cases are paid for when a physician does them and
13 they are not paid for when a dentist does them, the physician
14 is going to practise more and more dentistry and those patients
15 will be channelled not into the dental services of our hospitals.
16 It is going to have a serious impact on the training of the
17 future dentist.

18 THE CHAIRMAN: Is the delegation here from the
19 Christian Science Committee?

20
21 SUBMISSION OF THE CHRISTIAN SCIENCE CHURCH

22 Appearance: Leslie A. Tufts

23 THE CHAIRMAN: Are you alone, sir?

24 MR. TUFTS: Yes, all alone, Dr. Hagey.

25 THE CHAIRMAN: Were you here when the general



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THE CHAIRMAN: Are you alone, sir?

MR. TUTTS: Yes, all alone, Dr. Hagey.

THE CHAIRMAN: Were you here when the general



1 instructions were read at the opening?

2 MR. TUFTS: No. I just heard some of the last
3 delegation's remarks and the questions.

4 THE CHAIRMAN: I will just summarize them for
5 you. We have received copies of your brief and all members
6 of the Committee have read it and you are free to speak to
7 it or supplement it if you wish to. The members of the Enquiry
8 will ask questions of you, probably. It is not our intention
9 to debate your suggestions or recommendations, nor to state
10 the views of this Enquiry on them. Consequently, any opinions
11 expressed in questions asked or statements made by the members
12 of the Enquiry are intended for clarification only.

13 MR. TUFTS: Fine.

14 THE CHAIRMAN: Are you Mr. Tufts?

15 MR. TUFTS: Yes, that is correct.

16 THE CHAIRMAN: Would you proceed, sir?

17 MR. TUFTS: Thank you, Mr. Chairman. Mr. Chair-
18 man and ladies and gentlemen: we are principally interested in
5 19 having the proposed legislation, Bill 163, amended so that
20 Christian Scientists may receive Christian Science benefits
21 in lieu of medical benefits as provided under the Bill. To
22 this end, we call attention to Item 6(c) on the summary, which
23 reads:

24 "If plan is underwritten by private
25 insurance companies, payments to



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"If plan is underwritten by private

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1 Christian Science practitioners, and for
2 Christian Science nursing care and subsis-
3 tence while under Christian Science treat-
4 ment in a Christian Science Sanatorium,
5 nursing home, or in his own home, to be
6 authorized."

7 This is explained more fully on page 3 of the
8 brief, starting at line 3 and continuing to line 4, page 4.

9 I think by following this procedure we might just shorten the
10 presentation a bit, rather than going through the whole brief,
11 if that meets with your approval.

12 On page 3 of the brief, starting at line 3:

13 "We believe that, should a program under-
14 written by private insurance companies be
15 adopted, a Christian Scientist should be
16 entitled to receive payment for Christian
17 Science treatment by a Christian Science
18 practitioner, and for Christian Science
19 nursing care and subsistence in a Christian
20 Science sanatorium, nursing home, or in his
21 own home, while under Christian Science
22 treatment. However, we do not favor seeking
23 payment for the services of a Christian
24 Science practitioner in any program which
25 is administered entirely by the government,

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1 since we would not want to have our practi-
2 tioners placed under government regulation,
3 supervision, or control. Under such a
4 government-administered and supported program,
5 we would seek payment only for Christian
6 Science nursing care and subsistence in a
7 Christian Science sanatorium, nursing home,
8 or in the individual's own home, while under
9 Christian Science treatment.

10 "Therefore, we respectfully request that in
11 any health insurance legislation the term
12 'other remedial care' be included in addition
13 to authorized medical care. In using the
14 term 'other remedial care' it would need to
15 be understood that it is designed to include
16 nursing care for those relying on Christian
17 Science care and treatment. It would also
18 be expected that subsistence allowance, where
19 it is made available to those depending upon
20 medical care, would also be made available to
21 those relying upon 'other remedial care.'
22 The phrase 'other remedial care' is recommended
23 because it would permit the authorization of
24 Christian Science treatment and care without
25 being subject to attack as class legislation,



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1 as might be the case should the phrase

2 'Christian Science care' be used."

3 There are other provisions in our brief rela-
4 ting to the Christian Science position, in the event of
5 compulsory features being introduced, in which circumstances
6 we would seek exemption from the plan.

pw

7 This also applies to any plan administered
8 entirely by the Government which would have the effect of
9 bringing our practitioners under government regulation and
10 control.

11 Incidentally, the brief also makes reference
12 to nursing and subsistence care. I'm not sure that these
13 were intended under the Bill, so, if they're not, we can just
14 disregard that.

15 I am going to turn to page 5, if I may. I
16 would like to read again briefly from the brief, down at the
17 bottom of the page, the paragraph which begins:

18 "Christian Science treatment and care is
19 known to be a safe and effective therapeutic
20 system, so much so that Christian Science
21 practice is protected by law in every
22 province in Canada and every State in the
23 United States. For example, when the United
24 States Congress enacted the Social Security
25 Amendments of 1960, Public Law 86-778, known

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Amendments of 1950, Public Law 86-778, known



1 as the Kerr-Mills Act, a provision was
2 included authorizing 'any other medical care
3 or remedial care recognized under State law.'
4 Senate Report No. ---" thus and so, "---inter-
5 prets this phrase as follows:

6 'Accordingly, a State may, if it wishes,
7 include medical services provided by osteo-
8 paths, chiropractors, and optometrists and
9 remedial services provided by Christian
10 Science practitioners.'"

11 Then, down to the last paragraph on page 6:

12 "As previously indicated, recognition of our
13 method of healing would establish no precedent.

14 The United States Civil Service Commission's
15 Government-wide Indemnity Benefit Plan for
16 federal employees provides that any partici-
17 pant may elect to receive Christian Science
18 benefits in lieu of medical benefits, thus
19 preserving the right of Christian Scientists
20 to participate in the Plan without having to
21 compromise their religious rights and convic-
22 tions.

23 "In addition many insurance companies today
24 recognize Christian Science in their various
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"In addition many insurance companies today recognize Christian Science in their various health and accident policies, as well as in



1 liability and casualty policies. For example,
2 the new 'Connecticut 65' health insurance
3 plan for older citizens of Connecticut
4 includes recognition of Christian Science.
5 This plan underwritten by some of the leading
6 insurance companies domiciled in Connecticut,
7 is available to all citizens of that State
8 over 65 years of age."

9 Since this brief was prepared we received infor-
10 mation that a similar plan has been processed in the State of
11 Massachusetts. This is known as Massachusetts 65 Health
12 Insurance Association.

13 Now, just to conclude my presentation, at the
14 bottom of page 7:

15 "From the standpoint of religious freedom,
16 and in the interest of preserving that
17 sacred right, the Christian Scientists of
18 Ontario respectfully request that the term
19 'other remedial care' and the following
20 general provision be included in any health
21 insurance legislation:

22 'Nothing in this Act shall be construed to
23 require any person eligible for benefits
24 hereunder who relies on or is treated by
25 prayer or spiritual means alone by a duly



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1 accredited practitioner of a well recognized
2 church or denomination in accordance with the
3 tenets and practice of such church or denomi-
4 nation to undergo any medical or surgical
5 treatment. Such person shall receive bene-
6 fits as fully as if medical or surgical
7 treatment were employed."

8 May I say in conclusion that where such legis-
9 lation seems essential, we are in entire agreement with the
10 proposal now introduced, which makes coverage voluntary, and
11 provides for administration through participating insurance
12 carriers.

13 Our main interest is that Christian Scientists
14 who are residents of the province, as defined under the Bill,
15 should not be excluded from benefits under this Bill because
16 of their radical reliance upon the established and well-tested
17 system of spiritual healing of the Christian Science Church.

18 In view of the fact that Christian Science is
19 becoming so widely and generally recognized by insurance
20 carriers in the health insurance field, we feel that Christian
21 Scientists should not be restricted to medical insurance only
22 in a government-provided program of health insurance.

23 Now, one thing has appeared to me, Mr. Chairman,
24 since I've been reading this brief, and that is that Christian
25 Science treatment not only covers health conditions, but it



accredited practitioner of a well recognized church or denomination in accordance with the tenets and practice of such church or denomination to undergo any medical or surgical treatment. Such person shall receive benefits as fully as if medical or surgical treatment were employed.

May I say in conclusion that where such legislation is introduced, which makes coverage voluntary, and provides for administration through participating insurance companies.

Our main interest is that Christian Scientists should not be excluded from coverage under this Bill because of their radical reliance upon the established and well-tested system of spiritual healing of the Christian Science Church.

In view of the fact that Christian Science is becoming so widely and generally recognized by insurance companies in the health insurance field, we feel that Christian Scientists should not be restricted to medical insurance only in a government-provided program of health insurance.

Now, one thing has appeared to me, Mr. Chairman, since I've been reading this bill, and that is that Christian



1 covers rest and study and some other conditions that may exist
2 within the home, or something of that kind. So we would not
3 expect that that sort of coverage be given, or be included in
4 the Bill.

5 We would simply want this restricted to health
6 care only, and that's something that we made particular note
7 of in our interview with the Department of National Revenue
8 of the Federal Government, when they gave us recognition for
9 income tax purposes. This happened two or three years ago,
10 and we specified that this would be, that such recognition
11 would apply only to treatment for health care. We would not
12 feel it was fair to go beyond that point.

13 Now, I think that I might have other information
14 available on this, but do you feel that at this point, Dr. Hagey,
15 your Enquiry might want to ask questions?

16 THE CHAIRMAN: I know that some of our members
17 do. Dr. Butt?

18 DR. BUTT: Mr. Tufts, just to look at the first
19 page, in No. 6(a) you request exemption. I presume that is
20 exemption so that those who believe in Christian Science don't
21 have to buy insurance; is that correct?

22 MR. TUFTS: Well, we phrase this provision
23 vaguely so that it would cover any eventualities.

24 DR. BUTT: Well, specifically, is this what you
25 meant, then, by exemption?



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THE CHAIRMAN: I know that some of our members

DR. BUTT: Mr. Tobias, just to look at the first
page, in No. 6(a) you request exemption. I presume that is
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have to pay insurance; is that correct?

MR. TOBIAS: Well, we phrase this provision
vaguely so that it would cover any eventualities.
DR. BUTT: Well, specifically, is this what you

meant, then, by exemption?



1 MR. TUFTS: Exemption from?

2 DR. BUTT: From buying or purchasing insurance.

3 MR. TUFTS: Oh, yes, yes. That was the thought
4 there.

5 DR. BUTT: Well, it's on a voluntary basis.

6 In other words, there's no compulsion, so this has answered
7 that particular problem; is that correct?

8 MR. TUFTS: That can be disregarded unless
9 there is some change.

10 DR. BUTT: Further on you request, in No. 17,
11 inclusion in any health insurance legislation of the term
12 "other remedial care."

13 In other words, you mean that you would want
14 your people to be paid?

15 MR. TUFTS: Oh, yes, that's the thought that we
16 had in mind.

17 DR. BUTT: I've only one other question, and
18 this may seem a little on the technical side, but a case such
19 as, shall we say, appendicitis, would you explain to me a
20 little of how would this be treated, and what happens?

21 MR. TUFTS: Well, we are on the opposite side
22 of the fence here to the medical procedure, of course. Now,
23 when you mention appendicitis, why, I immediately think of
24 something that happened in my own home. This was about 20
25 years ago. My stepfather was seized with acute appendicitis.



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1 We had a medical doctor in and he diagnosed it as such. My
2 stepfather was not what we would call a Christian Scientist.
3 He had no objections, but I said to him after the doctor had
4 diagnosed the condition and recommended that he be taken to
5 the hospital quickly, "It's entirely your own choice. You
6 may have Christian Science treatment or you may have an opera-
7 tion, and you are the one who has to make the decision."

8 Now, Christian Science is not the practice of
9 medicine. It is the practice of religion. So my stepfather
10 decided he would lean entirely on Christian Science treatment.
11 We do make a point of this, Doctor, that you can't lean on
12 both. We find that that just doesn't make out in a practical
13 way; that it has to be one or the other, because, after all,
14 one is material and the other spiritual, and the two, we've
15 learned from experience, do not work well together.

16 So I also said to my stepfather, "Now, if you
17 want Christian Science treatment, it's got to be that, and
18 nothing else," and he said, "That's all right."

19 This was early on a Sunday afternoon, and before
20 the evening meal, through the services of a Christian Science
21 practitioner, and the practitioner didn't even come to the
22 house, this was what we call absent treatment, my stepfather
23 was relieved to the extent that he was able to have his meal
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1 days. He was doing manual labour, and he was completely
2 healed at that time.

3 There was no recurrence of the condition in the
4 15 years he lived beyond that point.

5 Therefore, that's the best example I can give
6 you, Doctor, of how that situation of appendicitis was cured
7 through Christian Science treatment at that time.

8 DR. BUTT: Would the same thing be true, say,
9 for a blood transfusion, where a person we feel is severely
10 in shock, and we feel that blood transfusion is indicated?

11 Would you take the same position?

12 MR. TUFTS: We don't make any distinction
13 between one physical condition and the other, because this
14 treatment is spiritual. It comes from complete reliance on
15 God.

16 DR. BUTT: You mentioned 8,000 Christian Science
17 practitioners. Is that in Ontario?

18 MR. TUFTS: Oh, no, that's a world-wide number.

19 DR. BUTT: How many would there be in Ontario?

20 MR. TUFTS: I think there are around 80. Less
21 than a hundred.

22 DR. BUTT: And then you note that they are
23 protected by the law in every province in Canada.

24 What do you mean by that statement? Do you
25 have your own Act?

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1 MR. TUFTS: No; there's provision -- I think we
2 have it here in the Appendix. There's reference here:

3 "Christian Science healing recognized by
4 law in Ontario."

5 It is found in The Drugless Practitioners' Act,
6 Section 10(d).

7 "Nothing in this Act shall apply to or affect,
8 (d) persons treating human ailments by prayer
9 or spiritual means as an enjoyment or exer-
10 cise of religious freedom."

11 DR. BUTT: The religious freedom of it?

12 MR. TUFTS: Yes; and then, of course, we have a
13 number of our churches in the province are incorporated under
14 Ontario law.

15 DR. BUTT: Well, the only other thing, I note
16 that in page 7 you say that the

17 "---religion of Christian Science demands
18 of its followers the strictest observance
19 of all laws pertaining to the prompt repor-
20 ting to the public health authorities of
21 suspected cases of infectious or contagious
22 diseases ---"

23 You do believe that this is not to be treated
24 quite the same as the other two conditions I gave you?

25 MR. TUFTS: Yes, we believe that the treatment

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MR. TURNER: Yes, we believe that the treatment



1 can be the same, but we're just pointing out here, Doctor,
2 that we're very careful to observe the public health laws in
3 regard to infectious and contagious diseases, and that we do
4 very strictly obey the law.

5 MISS McARTHUR: Mr. Chairman, although I recog-
6 nize Bill 163 doesn't, at the moment, include nursing services,
7 but it is in this brief, and is the word "nurse," without the
8 preface of Christian Science, as used on several occasions --
9 I was wondering if at any time legal recognition of this
10 individual has been sought under the statutes, in order to
11 obtain Registered Nurse, or Registered Nursing Assistant,
12 and how many of them do exist, even though they haven't had
13 legal recognition?

14 MR. TUFTS: We have a nursing service which is
15 known as the Toronto Nursing Service for Christian Scientists
16 Incorporated. This is an incorporation, you see.

17 Now, some of the nurses on the staff of this
18 group have come from the ranks of the registered nurses in the
19 medical profession. Some of them, but not all of them. Others
20 have come from a course, a three-year course, of nursing
21 training in our two Christian Science Sanatoriums, one of
22 which is in Chestnut Hill, Massachusetts, and the other in
23 San Francisco, California.

24 There is also a provision whereby nurses who
25 have had medical training can become Christian Science nurses,



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MRS. McARTHUR: Mr. Chairman, although I recognize Bill 103 doesn't, at the moment, include nursing services, but it is in this brief, and is the word "nurse," without the preface of Christian Science, as used on several occasions -- I was wondering if at any time legal recognition of this individual has been sought under the statutes, in order to obtain Registered Nurse, or Registered Nursing Assistant, and how many of them do exist, even though they haven't had legal recognition?

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1 provided that they meet the requirements of the Church, and
2 that means that they would have to become a member of the
3 Church, and would have to release their connection with the
4 medical nursing profession. These medical nurses can acquire
5 this status very quickly. They don't have to undergo the
6 three-year training that applies to those who are starting to
7 learn the nursing.

8 MISS McARTHUR: Would you require them to no
9 longer continue to maintain their status as a professional?

10 MR. TUFTS: As a medical nurse.

11 MISS McARTHUR: Rather than require them to
12 maintain their status, you require them to relinquish it?

13 MR. TUFTS: They have to relinquish that in
14 order to become a member of the Christian Science Church,
15 which is necessary in order to become a Christian Science
16 nurse.

17 MISS McARTHUR: Do you find in any circumstances
18 that such practitioners, after having worked within the Church
19 for any given period of time, go back into the field of employ-
20 ment outside of the Church without having adequate qualifica-
21 tions?

22 MR. TUFTS: Very, very seldom. There has been
23 an odd case, of course. I know of an odd case within our own
24 province, but it very seldom happens; very seldom. Of course,
25 a practitioner - there is a difference between the practitioner



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1 and the nurse, and in the nursing service, which is conducted
2 by our Christian Science nurses, there is, of course, no
3 medication, nothing of that kind. I would be glad to leave a
4 few copies of a brochure "Training Course for Christian Science
5 Nurses." I will be glad to leave copies with the Enquiry, if
6 any of you would like to have this brochure.

7 MISS McARTHUR: I would be interested in reading
8 it. Thank you.

9 MR. MULROONEY: Mr. Chairman, is the Christian
10 Science practitioner a clergyman?

11 MR. TUFTS: No, he is not. The Christian
12 Science Church is a church of laymen. We don't have ordained
13 clergy. To begin with we have in our churches what are known
14 as readers.

15 MR. MULROONEY: The brief, if I do not misunder-
16 stand, requests payment for the service of a Christian Science
17 practitioner?

18 MR. TUFTS: That's true.

19 MR. MULROONEY: Do you have a fee schedule?

20 MR. TUFTS: Well, nothing established, no.
21 There is a general rate, I would say. Of course, it depends
22 upon the area. The charges in Toronto, for example, might be
23 more costly than they would be in smaller rural areas, or in
24 rural areas throughout the province, or in smaller urban areas,
25 but I was just thinking about that after I came in here, and I



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1 expected that I would be asked this question.

2 Well, here it is: I think that I might say this,
3 that the average would be approximately \$3 a day for what we
4 regard as absent treatment. If there is a visit to the patient
5 involved, or the patient calls at the office of the practi-
6 tioner, then the rate might be four or five dollars per occa-
7 sion.

3 8 Now, the rates vary, I would say from \$2 per
9 treatment; that is, \$2 per day, to as high as four or five
10 dollars, depending upon the practitioner. Each practitioner
11 sets his own rate, but that is the general area, and I think
12 it's appropriate to mention right at this point that it is
13 stipulated that the rates charged by Christian Science practi-
14 tioners must be in the area of the rates charged by good
15 medical practitioners in the same area.

16 MISS McARTHUR: Then the rates vary according
17 to geographical area?

18 MR. TUFTS: To some extent, yes, but they do
19 keep within the field, within the area of medical rates in
20 the same area.

21 MISS McARTHUR: You speak of absent treatment
22 if the practitioner doesn't see the patient. Could you explain
23 to us how absent treatment can be given?

24 MR. TUFTS: Christian Science treatment is
25 wholly treatment by prayer. It's the application, through

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Well, here it is: I think that I might say this,

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by treatment by prayer. It's the application, through



1 prayer, of spiritual laws by God and man, and all of you know
2 your Bible, of course, and you know that there were occasions
3 on which Jesus healed without being in the presence of the
4 person who was healed.

5 That's what we mean by absent treatment. It's
6 treatment given by prayer, without being in the presence of
7 the individual who is given the treatment.

8 Then, of course, there is audible treatment,
9 which would have to be given in the presence of the patient.
10 That would constitute a call, either a visit to the patient
11 or the patient coming to the practitioner's office.

12 You see, in many cases, Christian Science treat-
13 ment by a practitioner is given to persons at some distance,
14 some considerable distance. In my own case, I've had requests,
15 and treatment in Christian Science is always by request --
16 I've had requests from England, and other countries around the
17 globe to give treatment, with considerable success. The
18 distance is no object, because it's God-given treatment, you
19 see, and there's just as much of God in one place as there is
20 in another.

21 MISS McARTHUR: I wonder, Mr. Tufts, if you
22 could tell us, do you diagnose a specific condition? We've
23 had an example of appendicitis a little earlier. If we used
24 pneumonia, or a heart condition, or this sort of thing, is the
25 treatment very prolonged? Are there more services to be paid



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MISS MARTIN: I wonder, Mr. Tait, if you could tell us, do you diagnose a specific condition? We've

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1 according to the type of illness that the person suffers, or
2 just what happens?

3 MR. TUFTS: Well, that depends. It depends
4 mainly upon the honesty of the patient. I'm going to word it
5 that way. It depends on his honesty in complying with the
6 instructions of the practitioner, for one thing; in his recep-
7 tivity to the treatment which is given, which is by prayer,
8 and along that line in general.

9 One can't determine beforehand just how long
10 treatment might be prolonged. It might be quick. There is
11 much healing of very serious physical conditions which comes
12 very quickly, and in other cases it might be prolonged.
13 There's just no way of knowing how long it's going to take.

14 So far as the diagnosis is concerned, Christian
15 Science practitioners do not diagnose. As I said a few moments
16 ago, this is the practice of religion, not the practice of
17 medicine, and we have to be very careful not to trample upon
18 the medical laws, because we might be in trouble if we did
19 that, and we don't have any desire to do that.

20 It's not necessary. A layman's account of what
21 the situation seems to be, the physical situation seems to be,
22 is generally sufficient for the need of the practitioner, but
23 if the patient wants to have a medical diagnosis, that is his
24 privilege.

25 MISS McARTHUR: One further question, Mr. Tufts:



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23 if the patient wants to have a medical diagnosis, that is his
24 privilege.



1 I take it, then, that all Christian Scientist practitioners
2 are of the same status? You don't have specialists of any
3 kind?

4 MR. TUFTS: No, no, we don't have any specia-
5 lists, and I wouldn't want to. Like medical men, men in other
6 professions, there are some that are better than others,
7 naturally, but in general the qualifications of the practitioner
8 are on a par with other practitioners.

9 I wouldn't like to attempt to break it down in
10 that category. We're referring here in our brief, of course,
11 to practitioners who are listed in the Christian Science
12 journal. There's a directory of all Christian Science practi-
13 tioners throughout the world in the Christian Science Journal.
14 There are also directories in here of our church organizations
15 throughout the world.

16 Now, all practitioners who are listed in this
17 Journal have to submit to the qualifications. They have to
18 prove themselves. They have to prove their ability to heal,
19 and this has to be done to the satisfaction of the Christian
20 Science Board of Directors of the Church, in Boston, Massa-
21 chusetts.

22 Now, that's one of the requirements for being
23 listed in this volume, in this official organ of the mother
24 Church, and another qualification is that everyone, every man
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1 must devote his whole time to the practice of Christian Science
2 healing. He's not allowed to engage in any other profession.
3 He must be devoting his whole time.

4 These people are representatives of the public
5 practice of Christian Science, and until they reach a point
6 where they are willing to devote their whole time to this
7 practice they can't be listed in this official directory, and
8 those are the people who we are asking recognition for in this
9 health insurance Bill.

10 MR. NAYLOR: Just one question, Mr. Tufts.
11 You indicated that a Christian Science practitioner doesn't
12 diagnose illness, and I take it, then, that the practitioner
13 would give treatment, either personal treatment or absent
14 treatment, whenever requested by the individual.

15 If the insurance plan paid for Christian Science
16 treatment, what protection would there be against an individual
17 using it very freely, and maybe more frequently than really
18 necessary?

19 Of course, there would be the honesty of the
20 patient, but would there be any protection against that, such
21 as we have when we pay benefits for medical treatment when the
22 doctor actually diagnoses the condition?

23 MR. TUFTS: Yes, I feel that there is added
24 protection here, Mr. Naylor. I am glad to see you here this
25 afternoon. We've met before.



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22 doctor actually diagnoses the condition?
23 MR. TELFORD: Yes, I feel that there is added
24 protection here, Mr. Naylor. I am glad to see you here this
25 afternoon. We've met before.



1 I think, too, that you can add to that the
2 honesty of the Christian Science practitioner. In other words,
3 I think that there is a well-established precedent here, that
4 a certificate would be accepted; a certificate signed by a
5 Christian Science practitioner would be accepted. This is
6 done generally in the national plan of the United Kingdom,
7 and it's done in many other cases, by insurance companies,
8 especially, in the United States.

9 I can cite coverages here in which that plan
10 is proving satisfactory. Now, as I said, you would have the
11 honesty of the Christian Science practitioner back of this,
12 and one thing here that I notice, we don't like this idea,
13 but this is in the Connecticut 65 Associated Connecticut
14 Health Insurance Companies, and there is one paragraph here
15 in a letter which was written by one of the officials through
16 our publication in Hartford, Connecticut:

17 "It should be kept in mind that the associated
18 companies reserve the right in all cases to
19 medically examine a claimant if they consider
20 that the need for such examination is indicated
21 because of insufficiency of evidence in support
22 of the claim, or for other reasons."

23 Now, we want to be absolutely fair to insurance
24 carriers in a plan of this kind, and if they feel that some-
25 thing of that kind should be the privilege of the insurance

[illegible]

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1 company, we'll go along with it. While we don't, as I said a
2 moment ago, we don't like it, we'll go along with it, because
3 we do want to be absolutely straightforward on this thing.

4 4 MR. WHITNEY: Just two brief questions, Mr.
5 Chairman. I'm aware our time is running along, and we're
6 getting behind schedule.

7 On page 6, Mr. Tufts, you mention the Kerr-
8 Mills Act and you refer to the enabling section that enabled
9 the States to include such remedial services provided by
10 Christian Science practitioners.

11 Do you know offhand just how many States avail
12 themselves of the enabling section to do so?

13 MR. TUFTS: You know, you've put your finger on
14 one thing that I didn't want a question on. I would be glad
15 to get that information for you, if you really want to have it.

16 MR. WHITNEY: Fine. If you would care to send
17 it in.

18 MR. TUFTS: I shall be glad to do that. This
19 is just a reference that was given to us by our Head Office in
20 the States, and I don't have information on it, other than what
21 is here in the brief.

22 MR. WHITNEY: In Canada, do you know what
23 carriers are covering this type of care now, or in Ontario?

24 MR. TUFTS: Well, our biggest success in this
25 line, and Mr. Naylor knows this, has been, and is, in the



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1 United States; now we have had very major recognition there.
2 There's this plan which came into effect a couple of years ago.
3 I think it was November 1st, 1961, whereby the -- I don't want
4 to prolong the time here -- whereby the Government-wide Indem-
5 nity Benefit Plan, approved by the United States Federal Civil
6 Service Commission -- now, this is a plan which I think is
7 going to be quite parallel to, in a sense, parallel to what
8 we're asking, or what is going to be legislated here in
9 Ontario, and in this particular plan there are approximately
10 five million members.

11 MR. WHITNEY: That's not quite my question, Mr.
12 Tufts. All I wanted was the carriers.

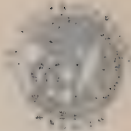
13 MR. TUFTS: Well, we've had some individual
14 recognition here in Canada. There are a few companies, I
15 don't know whether it's ethics here to mention the names of
16 insurance companies or not.

17 MR. WHITNEY: It's quite all right.

18 MR. TUFTS: There have been a few insurance
19 companies, and we have approached others. We do know that the
20 Insurance Company of North America will pay fees of Christian
21 Science practitioners in lieu of payment to a medical doctor.

22 Incidentally, in our request for payment to
23 practitioners, we're not asking for concurrent payment. This
24 would apply on all medical liability policies.

25 Also the Phoenix of London group, which consists,



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1 I understand, of four companies, will make similar payments.

2 Now, there is the Mutual of Omaha. The Mutual
3 Benefit and Health, the Travelers', Occidental Life, and Great
4 West Life.

5 Now, most of these have given individual recog-
6 nition to the request for Christian Science treatment and care,
7 but the Great West have recognized it in a small way in regard
8 to group health insurance coverage.

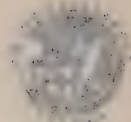
9 Now, that's about the extent of my information.

10 MR. WHITNEY: Thank you very much. That
11 answers my question, sir.

12 DR. GALLOWAY: I've only one; really in two
13 parts. Throughout your brief you speak of prevention. Is
14 this done entirely by prayer, or do you recommend to your
15 people that they avail themselves of vaccination, and polio
16 vaccines, et cetera?

17 The final question is that you have spoken
18 throughout your brief only of illness. What happens to trauma,
19 and broken bones? Do you recommend to them to avail themselves
20 of Christian Science people, or to take out some accident
21 policy to entitle them to this treatment?

22 MR. TUFTS: Well, Dr. Galloway, I'll take the
23 latter part of your question first. There it is entirely up
24 to the individual. We don't attempt to influence our members
25 in any way whatsoever as to whether they should carry, or should



OFFICE OF THE
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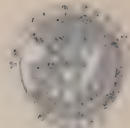
1 not carry accident insurance. That is entirely up to the
2 individual, but certainly Christian Science treatment does
3 cover the areas which you have mentioned.

4 I'm thinking now of a case of broken bones,
5 also within my own family, because there are many others
6 recorded, but I feel I can speak with conviction within our
7 own experience, and this was the case of a broken wrist.

8 My wife fell down the basement stairs and broke
9 her wrist. She was given Christian Science treatment for a
10 period of 24 hours, and there was very noticeable relief at
11 the end of that time.

12 She said, "I think I would like to have this
13 break x-rayed," so I said, "Fine, we'll have a doctor come
14 in and make arrangements." I wasn't acquainted with any
15 medical practitioner. I located one, and he said, "Get your
16 wife over to Western Hospital for an x-ray." After the x-ray
17 was taken he walked towards us with his head bowed, and he
18 said, "You know, this is amazing. All the small bones in the
19 wrist are broken," but he says, "They are set. They are
20 perfectly set, and are knitting. Now," he said, "I wouldn't
21 disturb them for the world. I'm just going to put a support
22 on the arm," and he put a bandage around it. He said, "I'm
23 not even going to put a cast around it." He saw my wife in a
24 week or ten days, and found the arm perfectly healed.

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24 week or ten days, and found the arm perfectly healed.

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1 Science can do in the case of broken bones. It is made plain
2 in our textbooks on health, although this type of healing is
3 the last which will be acknowledged, and if the Christian
4 Scientist practitioner wishes to do so he may make available
5 the services of a surgeon.

6 I believe I've forgotten just what the other
7 question was.

8 DR. GALLOWAY: It was whether your people
9 avail themselves of the various vaccines for the prevention
10 of disease.

11 MR. TUFTS: There again, Doctor, it's up to
12 the individual. Ordinarily, a Christian Scientist would not
13 do that. We find that Christian Science, an application of
14 the understanding of Christian Science, which is not faith
15 healing, incidentally, is quite equal to meeting all conditions
16 of that kind.

17 We have, as you know, the privilege of having
18 our children exempt in the schools from inoculations, vaccina-
19 tions, medical attention of all kinds. Now, that privilege
20 has existed for a period of all of 25 years, and it has worked
21 well under the Christian Science method, and I can't recall
22 any instances where we had any difficulty as a result of that,
23 and certainly it applies to the adult as well as to the child.
24 We find it most effective in that area.

25 THE CHAIRMAN: Do the members of your faith



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THE CHAIRMAN: Do the members of your faith



1 have similar privileges when travelling abroad?

2 MR. TUFTS: Oh, yes, indeed. Similar privileges?

3 THE CHAIRMAN: They are exempt from being
4 required to have vaccinations?

5 MR. TUFTS: Well, it all depends on what the
6 regulations might be in those areas. We would have to
7 subscribe to those. For example, going overseas to Continental
8 Europe and the old country, I think that there are no require-
9 ments there regarding smallpox vaccination, in which case you
10 don't have it, but if it was called for we would have to have
11 it, yes.

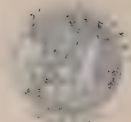
12 THE CHAIRMAN: Do you have any further comments,
13 sir?

14 MR. TUFTS: I think that just about covers it.
15 I could talk for quite a long while, but I know your time is
16 precious, and I'm very grateful to the Enquiry, and if there is
17 any more information that is needed, I'm at your service any
18 time.

19 THE CHAIRMAN: Thank you very much, sir.

20 MR. TUFTS: I would like to leave these
21 brochures for any members of the Enquiry who would like to
22 have them, and I'll respond to your request on that question
23 of yours, Mr. Whitney.

24 Thank you very much for a very courteous and
25 kindly reception.



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1 THE CHAIRMAN: Is there a delegation here from
2 the Ontario Society of Physiotherapy?

3
4 SUBMISSION OF THE ONTARIO SOCIETY OF PHYSIOTHERAPY

5 Appearances: Robert F. Clark
6 Jean M. Fagan

7 THE CHAIRMAN: Were you here and heard the
8 instructions I read to the previous delegation?

9 MR. CLARK: Yes. We have little to add to our
10 brief. We are properly identified as the Ontario Society of
11 Physiotherapy, incorporated in 1926, under provincial charter.
12 All of our members are registered physiotherapists in the
13 Province of Ontario, and principally are in private practice,
14 although we do have some in institutional practice.

15 I don't believe that there is anything that we
16 would like to enlarge upon, and we're primarily here to answer
17 questions if our brief has been found wanting in some way or
18 other.

19 THE CHAIRMAN: Well, I know that there are some
20 questions to be asked, but it is not necessarily because your
21 brief has been found wanting.

22 MISS CARPENTER: What relationship does the
23 practitioner of physiotherapy have with the practitioner of
24 medicine?

25 Would you treat a patient who wasn't under



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MISS CAHNETER: What relationship does the

practitioner of physiotherapy have with the practitioner of

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Would you treat a patient who wasn't under



1 medical care?

2 MR. CLARK: Primarily, no. Where remedial
3 therapy is required, we treat under the direction or prescrip-
4 tion of a competent physician or surgeon.

5 MISS CARPENTER: The question arose on the
6 second page of your brief, where you said under 2.A. that you
7 would treat many patients in smaller centres where no other
8 services are available.

9 I wonder if you would explain that?

10 MR. CLARK: No other services available would
11 refer to a smaller hospital, which didn't have sufficient size,
12 or beds, to warrant the establishment of a clinic within that
13 hospital. Then a private practitioner could, in this case,
14 perform the dual role, and serve the community.

15 MISS CARPENTER: When you say that a large
16 percentage of your physiotherapists are in private practice,
17 could you enlarge on that? What percentage of your practi-
18 tioners are salaried people, and what percentage rely entirely
19 on private practice?

20 MR. CLARK: I would imagine 10 or 15 per cent
21 of our people are employed in institutional work, and the
22 balance in private practice.

23 MISS CARPENTER: What fee do you charge for
24 service to a patient?

25 MR. CLARK: The fee varies. The Workmen's



1 Compensation Board pay \$2.50 per treatment, and the average
2 would run between, oh, I would think four to six dollars,
3 depending upon the location of the physiotherapist and the
4 type of treatment involved.

5 MISS CARPENTER: And you would like to see this
6 Act amended, I gather, to include physiotherapy as a benefit
7 under the Act, or is it an exception under the Act?

8 MR. CLARK: As a benefit under the Act. The
9 Ontario Hospital plan already covers physiotherapy given in
10 hospital, and we feel this works a hardship on the patient,
11 whereby they require physiotherapy, and as long as they are
12 in hospital they aren't entitled to payment under the Ontario
13 Hospital Act when they leave the hospital, and still require
14 physiotherapy through the hospital, or through their private
15 practitioner, they must pay for their treatment by themselves,
16 or if they are covered by an insurance company, then the
17 insurance company will pay the fee.

18 MISS MCPHERRIN: I did wonder a bit about the

19
20 presently open, and do you have a shortage?
21 Coming from the nursing profession, we under-
22 stand a bit about shortages, and we wondered whether the same
23 thing occurs in these other varieties of team members?

24 MR. CLARK: At the Conference on Physiotherapy
25 in 1962, they projected the figure that we were currently



1 500 physiotherapists short. This was in May, 1962. They
2 projected the figure of 1,000 short within five years - within
3 a five-year period - unless training facilities were increased
4 and the field of physiotherapy made more attractive to entice
5 people to enter the field and fulfil the prerequisite studies.

6 One of the things which, of course, has limited
7 the field is the salary schedule as we find in institutional
8 work.

9 MISS McARTHUR: Mr. Chairman, the suggestion
10 in the brief is indicating a plan that might be considered
11 desirable, that the ability to carry forward a program of
12 extended services at this time would have very real problems;
13 is this a fair statement? Once one moves the practitioners
14 into the field of private practice, you do not really handle
15 as many, or do you see them handling as many situations as
16 they can under the present plan?

17 MR. CLARK: I think there is a general need
18 for both types of physiotherapy and the demand is there and I
19 think the demand will be met future-wise; but I think this is
20 the time to project the need of greater coverage.

21 MISS McARTHUR: This was really my question,
22 Mr. Chairman, the fact that this did seem largely in the area
23 of projection rather than what would be possible in implemen-
24 tation and I wanted to be sure I was not misinterpreting that.

25 THE CHAIRMAN: Dr. Hamilton?



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1 DR. HAMILTON: Thank you, Mr. Chairman. Mr.
2 Clark, I think there is something I did not hear quite
3 correctly. You said that 10-15% of the physiotherapists
4 registered in Ontario were working in institutions?

5 MR. CLARK: No, sir. Ten to fifteen per cent
6 of our Society who are registered physiotherapists. If I was
7 misunderstood, I was referring specifically to our Society,
8 not the registration of the province. The figures would be
9 completely reversed, I would think, provincially.

10 DR. HAMILTON: Yours is the Ontario Society of
11 Physiotherapy?

12 MR. CLARK: Yes, sir.

13 DR. HAMILTON: It represents what proportion
14 of the physiotherapists in the province?

15 MISS FAGAN: Licensed physiotherapists for the
16 Province of Ontario -- there are something like 546 licensed
17 practitioners in physiotherapy in the 1963 list of registrants
18 under the Board of Directors of Physiotherapy.

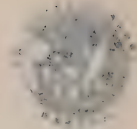
19 MR. WHITNEY: That is in Ontario?

20 MISS FAGAN: Yes.

21 DR. HAMILTON: How many are members of the
22 Ontario Society?

23 MR. CLARK: In the area of 40, who are in active
24 practice.

25 DR. HAMILTON: So you are representing then



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DR. HAMILTON: So you are representing them



1 about 40 physiotherapists who are engaged in the private prac-
2 tice of physiotherapy?

3 MR. CLARK: Of that 40, there would be approxi-
4 mately 10 to 15 in institutional work and the balance would be
5 in private practice. Some do part-time private practice as
6 well as their role in institutions.

7 DR. HAMILTON: Yes. But the majority of the
8 members of the Society, then, are engaged principally in the
9 private practice of physiotherapy?

10 MR. CLARK: Right.

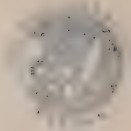
11 DR. HAMILTON: Now, Mr. Clark, you said that
12 you give treatment to patients, or members of your Society
13 give treatment to patients upon the prescription of a physician
14 who will refer a patient to you?

15 MR. CLARK: That is correct.

16 DR. HAMILTON: Do you accept patients who are
17 not referred by a physician?

18 MR. CLARK: The only time that this would be
19 done would be on straight tonic work and, to my knowledge,
20 most physiotherapists in private practice are needed princi-
21 pally in remedial work.

22 DR. HAMILTON: I do not understand what that
23 answer means, in terms of my question. Do you mean, then,
24 that the physiotherapists engaged in private practice are
25 treating, almost exclusively, patients referred by a physician?



line of psychiatry?

MR. CLARK: Of that no, there would be approxi-
mately 10 to 15 in institutional work and the balance would be
in private practice. Some do part-time private practice as
well as their role in institutions.

DR. HAMILTON: Yes. But the majority of the
members of the Society, then, are engaged principally in the
private practice of psychiatry?

MR. CLARK: Right.

DR. HAMILTON: Now, Mr. Clark, you said that
you give treatment to patients, or members of your Society
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1 MR. CLARK: That is correct, sir.

2 DR. HAMILTON: But there are some patients not
3 referred by a physician?

4 MR. CLARK: Where a physiotherapist would be
5 employed by a health club and the treatment is tonic.

6 DR. HAMILTON: Employed by a health club?

7 MR. CLARK: Yes. If such were the case, then,
8 there is not the necessity of prescription.

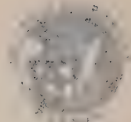
9 DR. HAMILTON: Thank you very much.

10 THE CHAIRMAN: Mr. Clark, how does it happen
11 that your Society has such a small percentage of the physio-
12 therapists as members; 40 out of 500 and some odd? Am I right
13 in that?

14 MR. CLARK: The other people are principally
15 members of the Canadian Physiotherapy Association and these
16 are primarily female and our Society is principally male,
17 although we do have several female members. Most of the C.P.A.
18 registrants are engaged primarily in institutional work,
19 rather than private practice. They do have some members who
20 are in private practice, but principally they are engaged
21 within institutional work.

22 THE CHAIRMAN: Mr. Major?

23 MR. MAJOR: Mr. Clark, I gather, then, that
24 practically all physiotherapy is done under the direction of a
25 physician?



MR. CLARK: That is correct, sir.

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1 MR. CLARK: Yes, sir.

2 MR. MAJOR: Whether it is in private practice
3 or in an institution? What is the relationship of occupational
4 therapy and physiotherapy? Do you do both?

5 MR. CLARK: No, I do not do both. There is a
6 combined force currently of occupational and physiotherapy.
7 Perhaps Dr. Godfrey can clarify that.

8 MR. MAJOR: Are there separate organizations?
9 You have got an Ontario organization of physiotherapists. Do
10 you have an Ontario association of occupational therapists?

11 MR. CLARK: I do not believe, as such. I
12 believe there is a section under the Canadian Physiotherapy
13 Association for a combined therapist, where you have a dual
14 role. But, I am not qualified to answer that because I do not
15 know. I am presuming.

16 MR. MAJOR: Mr. Chairman, is this the only
17 brief we have on record from physiotherapy?

18 MISS McARTHUR: May I ask just one question
19 while you are looking for that? Can you tell me what propor-
20 tion of the 40 members, or what proportion of your private
21 practitioner members are Canadian-trained; or are they largely
22 trained in other parts - Europe, particularly? Just roughly.

23 MR. CLARK: I would think the majority are
24 Canadian-trained. Some of the Canadian-trained are retrained.
25 In other words, re-qualified people from Europe, people who



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Canadian-trained. Some of the Canadian-trained are retained.



1 have re-qualified since arrival in Canada. I would give, as a
2 proportion, better than half.

3 MISS McARTHUR: Better than half? Thank you.

4 THE CHAIRMAN: Yes. I believe this is the only
5 one.

6 MR. MAJOR: To assist us, Mr. Chairman, I would
7 like to broaden the list a little bit and get more information
8 on this, because I am impressed with the work that physiothera-
9 pists are doing. I am impressed with the speech therapists
2 10 and the occupational therapists, particularly in the care of
11 psychotics and occupational therapy that is being done with a
12 great deal of success, as far as I know. One of the things
13 that has interested me in this area, because we are interested
14 in it in the insurance industry, is the fact that it is very
15 difficult to get a physiotherapist in many parts of the
16 Province of Ontario and I think it has been established that
17 you are short and on page 4, Item D, you say that one of the
18 things that would help this situation is a realistic salary
19 schedule to induce male physiotherapists to enter the field.
20 Is this common across Canada, or is it common in Ontario that,
21 as you say, there is a depressed fee schedule?

22 MR. CLARK: Yes. I believe it is common across
23 Canada and this is one of the reasons that we lose the export
24 physiotherapists, unwillingly, to the United States.

25 MR. MAJOR: Yes. I was coming to that.



1 THE CHAIRMAN: Yes. I believe this is the only
2 one.
3 MR. MAJOR: To answer us, Mr. Chairman, I would
4 like to mention the fact that the insurance industry
5 is not a monopoly. It is a competitive industry
6 and the fact that it is a competitive industry
7 is the reason why it is not a monopoly.
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20 MR. MAJOR: Yes. I was coming to that.



1 MR. CLARK: We train the people and our American
2 counterparts get the advantage.

3 MR. MAJOR: I understand that practically every
4 State of the Union has an examination for physiotherapists
5 before they can practise in that State and this examination
6 is readily passed by a graduate of the University of Toronto;
7 is that so?

8 MR. CLARK: I believe that is the case.

9 MR. MAJOR: It is interesting to me to note
10 that in the salary surveys of the Dominion of Canada the lowest
11 paid teaching staff of universities in this country are physio-
12 therapy teachers. Is my information fairly right in this?

13 MR. CLARK: I would think you would be correct.
14 I am not conversant with the salary schedule.

15 MR. MAJOR: In other words, we need a motivation
16 here to get people into this business and part of it is salary?

17 MR. CLARK: Salary is definitely.

18 MR. MAJOR: Are the salaries in institutions as
19 depressed as the private fees, apparently, are?

20 MR. CLARK: Yes. I would say definitely that
21 this is the case.

22 MR. MAJOR: How many students are there in the
23 University of Toronto physiotherapy course - male students?

24 MR. CLARK: Can I ask Dr. Godfrey to answer that
25 question, Mr. Chairman?

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MR. CLARK: We train the people and our American



1 THE CHAIRMAN: Yes, certainly.

2 DR. GODFREY: I think Mr. Clark is quite right
3 in not answering that. He would not have direct knowledge of
4 that. There are no male students at the present time. There
5 is provision for male students coming in. There have been
6 applications filed at one time or another but it seems that
7 when one male is in the midst of about 280 girls, he becomes
8 discouraged.

9 MR. MAJOR: How many students are there in the
10 freshman year this year?

11 DR. GODFREY: I believe there are 112 in the
12 freshman year this year.

13 MR. MAJOR: And no males?

14 DR. GODFREY: No, sir.

15 MR. MAJOR: Mr. Chairman, I wonder if we can
16 get an answer to the rate paid, on a comparative basis. We
17 have heard some discussion this afternoon on team work. If
18 team work means anything, I suppose that there are certain
19 areas where the physiotherapist is needed, the same as a nurse
20 or a social worker. Is there any wide divergence in the pay of
21 these people?

22 MR. CLARK: I do not know that you can draw a
23 comparison between the nurses' schedules and the physiothera-
24 pists'.

25 MR. MAJOR: Mr. Clark, thank you very much. As



THE CHAIRMAN: Yes, certainly.

DR. GORMLEY: I think Mr. Clark is quite right in not answering that. He would not have direct knowledge of applications filed at one time or another but it seems that when one male is in the midst of about 250 girls, he becomes discouraged.

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1 the Chairman has said, there is no other submission regarding
2 physiotherapy and I have been trying to explore the field a
3 little broader than maybe I should have. I am much obliged
4 for your answers.

5 THE CHAIRMAN: Dr. Galloway?

6 DR. GALLOWAY: Thank you. I think you brought
7 forward, Mr. Clark, that there is quite a distinct difference
8 between the Association and the Society of Physiotherapists.
9 I am interested in exploring a little further what this
10 differentiation is. What are the qualifications of entering
11 the Society?

12 MR. CLARK: You must be a registrant of the
13 Provincial Board of Directors for Physiotherapy, to be consi-
14 dered as a candidate for membership within the Society.

15 DR. GALLOWAY: And are the qualifications for
16 the registered physiotherapist the same for those thousands
17 of females that Dr. Godfrey speaks about and yourselves; or
18 is there a difference? Do you try the same examinations?

19 MR. CLARK: The same examinations are set by
20 the Board for registration within the province, yes. A pre-
21 requisite to practise within the province is that you must
22 qualify under the Board of Directors of Physiotherapy, which
23 is a division of the Drugless Practitioners' Act.

24 DR. GALLOWAY: Would your training program be
25 the same as those of the members of the Association?



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MR. GALLOWAY: Would your training program be



1 MR. CLARK: It is considered equivalent under
2 the jurisdiction of the Board.

3 DR. GALLOWAY: If there is a difference, where
4 do you take your training, if it is different?

5 MR. CLARK: To go back, when I completed my
6 service, at the completion of the war in 1945...

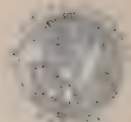
7 DR. GALLOWAY: Pardon me, I was not being
8 personal.

9 MR. CLARK: No.

10 DR. GALLOWAY: Any physiotherapist?

11 MR. CLARK: A good number of our people, as I
12 have said, are re-trained people who were therapists in
13 Europe and, on arriving here, they sought re-training. Now,
14 they have, in some cases, taken their training at the Canadian
15 Institute of Physiotherapy, to bring them up to a standard
16 which the Board of Directors or the Drugless Practitioners' Act
17 would recognize as an equivalent. Many of our other people
18 are Chartered Society people from England, who have come to
19 Canada and gone into private practice and, as such, felt that
20 the Ontario Society could offer more to them than a membership
21 in the Canadian Society.

22 DR. GALLOWAY: Do you have any place now in
23 Ontario for training, to become a member of this Society,
24 other than through the universities in the same group of the
25 Association?



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the jurisdiction of the Board.

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Canada and gone into private practice and, as such, felt that

the Ontario Society could offer more to them than a membership

in the Canadian Society.

DR. GALLOWAY: Do you have any place now in

Canada for training in chiropractic?

MR. CLARK: There is no place in Canada for training in



1 MR. CLARK: No.

2 DR. GALLOWAY: How will you add to your ranks
3 from now on?

4 MR. CLARK: Only by members from the C.P.A. or
5 people arriving from Europe who feel that they want to go into
6 private practice and the Ontario Society can offer them more
7 than possibly the C.P.A., which is primarily geared to insti-
8 tutional physiotherapy.

9 DR. GALLOWAY: Do your qualifications entitle
10 you to make application and to accept a job in a hospital?

11 MR. CLARK: Yes. A teaching hospital, I do not
12 know. We do have members in hospitals, in general hospitals,
13 throughout the province; but teaching hospitals, I do not
14 believe so.

15 DR. GALLOWAY: You have been speaking, through-
16 out your brief, of salaries. Today you have been speaking of
17 fees for the treatment of patients. If you are in private
18 practice, does a salary actually come into this?

19 MR. CLARK: I think perhaps the coincidence of
20 the two is in regard to projecting some sort of a basis under
21 any projected health insurance coverage. Why we stayed out of
22 the area of statistics and finance was that we did not feel
23 that we were competent and such should be developed by persons
24 who have all the knowledge and qualifications to develop or
25 project future scales.

MR. CLARK: No.

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3 1 DR. GALLOWAY: How many patients would the
2 average physiotherapist in private practice treat a day?

3 MR. CLARK: It depends entirely upon the indivi-
4 dual's practice, the type of practice he was doing. It would
5 vary from 15 to 30 a day.

6 DR. GALLOWAY: Thank you very much.

7 THE CHAIRMAN: Mr. Clark, I understand from a
8 comment or statement that you made previously, that a very
9 large percentage of the patients who are treated by physio-
10 therapists come to them either as being referred to them or
11 on a prescription of a physician. Might that indicate that
12 if it were possible to include payment for physical therapy
13 under the Act, on a basis of it being a referral or a prescrip-
14 tion basis, that that would be satisfactory to the physiothera-
15 pist?

16 MR. CLARK: Yes, that would be completely in
17 accord with the Drugless Practitioners' Act, that such be done.

18 MR. MAJOR: I have one more question and this
19 is not being facetious. I am merely interested. On page 8,
20 you have "The Prayer of Maimonides." Who is that?

21 MR. CLARK: He was a philosopher in, I think,
22 around 1600, in Spain. He was a Jewish philosopher in Spain.
23 This is one of his little gems that we cultivated as an adjunct
24 to our constitution and bylaws, which we have each member sign.

25 MR. MAJOR: Thank you.

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1 MR. CLARK: We also have it in printed form
2 which the practitioner can frame and hang in his office,
3 showing that he subscribes to this philosophy.

4 THE CHAIRMAN: Dr. Butt?

5 DR. BUTT: Have you any relationship at all
6 with the remedial gymnasts?

7 MR. CLARK: Not a direct relationship, but many
8 male physiotherapists are also remedial gymnasts.

9 DR. BUTT: They do overlap; is this correct?

10 MR. CLARK: Only that in many instances there
11 is a dual function. You do not have to be a physiotherapist
12 to be a remedial gymnast, although some male physiotherapists
13 are remedial gymnasts.

14 DR. BUTT: Do you do work directly under the
15 doctor - that is, within his office? Would you be working for
16 them, or is it in your own shop?

17 MR. CLARK: No. Speaking personally, I have my
18 own practice and Miss Fagan has her own practice in Hamilton
19 and we take direction from, oh, several - many.

20 DR. BUTT: I realize that you are not working
21 as part of an individual doctor team or anything. I mean,
22 under one man who is a doctor in physical therapy, as such,
23 in the true sense of the word? Now, some of them do carry on
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1 private practice is where the physiotherapist has his practice.

2 DR. BUTT: That is, you have your own private
3 practice?

4 MR. CLARK: That is correct.

5 DR. BUTT: I have tried to find out exactly
6 what you wanted, because everybody is very specific about
7 what they want out of the Bill. As I understand it, it is
8 the benefit to be paid to you directly. In other words,
9 include physiotherapy as a benefit under the Act?

10 MR. CLARK: Include the private practitioner
11 in physiotherapy within the structure of a health insurance
12 plan.

13 DR. BUTT: This is a Bill.

14 MR. CLARK: Yes.

15 DR. BUTT: We are dealing with Bill 163.

16 MR. CLARK: Yes. We feel that it is discrimina-
17 tory in regard to the patient where he can have his treatment
18 in hospital but cannot have it paid for...

19 DR. BUTT: You must remember that that is not
20 under this Bill.

21 MR. CLARK: No.

22 DR. BUTT: That is an entirely different situa-
23 tion.

24 MR. CLARK: No. I am using that as an example
25 as to what we hope for the future, that the Ontario Hospital



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1 Association coverage will be expanded to cover private practice.

2 DR. BUTT: Thank you.

3 THE CHAIRMAN: Mrs. Aylen?

4 MRS. AYLEN: Do you think that the fact that the
5 patient in a hospital is getting physiotherapy, that that
6 might delay their discharge?

7 MR. CLARK: I do not think it is supposed to,
8 under the Ontario Hospital Association.

9 MRS. AYLEN: I know it is not supposed to, but
10 do you think it happens?

11 MR. CLARK: It may happen. I am not qualified
12 to say. But I do not believe it is supposed to happen, but I
13 do believe that he may not be retained for physiotherapy only
14 and he may be brought back as an out-patient. I think this
15 is the way it is supposed to go.

16 MR. CASWELL: Is this shortage of physiothera-
17 pists primarily a male shortage?

18 MR. CLARK: We are short of both male and
19 female. We are acutely short of females.

20 MR. CASWELL: Are you short of female for
21 institutional or for private?

22 MR. CLARK: We are short of female for institu-
23 tional, but I feel that we are short of all types of physio-
24 therapists for private practice because we have many small
25 centres with no service and patients have to be transported

DR. BOYD: Thank you.

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do you think it happens?

MR. CLARK: It may happen. I am not qualified

to say. But I do not believe it is supposed to happen, but I

do believe that he may not be retained for physiotherapy only

and he may be brought back as an out-patient. I think this

is the way it is supposed to go.

MR. CASWELL: Is this shortage of physiother-

apists primarily a male shortage?

MR. CLARK: We are short of both male and

female. We are acutely short of females.

MR. CASWELL: Are you short of female for

institutional or for private?

MR. CLARK: We are short of female for institu-



1 a great distance, in many cases, to receive adequate care.

2 MR. CASWELL: It would appear that the majority
3 of physiotherapists are working in hospitals, on salaries?

4 MR. CLARK: The majority are, yes.

5 MR. CASWELL: And inclusion in this Bill would
6 not, as a result, help encourage any greater fee in that direc-
7 tion. It would help to encourage a greater fee to private
8 practice, but there is no reason to believe it would increase
9 the salaries paid in a hospital. So I am just wondering how
10 you are going to encourage them with the inclusion in this
11 Bill.

12 MR. CLARK: The Canadian Physiotherapy Associa-
13 tion does project scales as a basis for salary of institu-
14 tional physiotherapists.

15 MR. CASWELL: Yes; but regardless of whether
16 included in this Bill or not?

17 MR. CLARK: Yes.

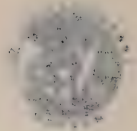
18 MR. CASWELL: Thank you.

19 THE CHAIRMAN: Are there any further questions?

20 MR. SIMON: Who sets the fee for service
21 rendered on a private basis?

22 MR. CLARK: We, as a Society, recommend the
23 basis for fees; but nobody has set a fee as such.

24 THE CHAIRMAN: Are there any further questions?
25 Do you have any further comments, Mr. Clark?



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10 you are going to encourage them with the inclusion in this

11 Bill.

12 MR. CLARK: The Canadian Physiotherapy Associa-

13 tion does project scales as a basis for salary of institu-

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15 MR. GARDNER: Yes; but regardless of whether

16 included in this Bill or not?

17 R. CLARK: Yes.

18 MR. GARDNER: Thank you.

19

20 THE CHAIRMAN: Are there any further questions?

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23 rendered on a private basis?

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25 MR. CLARK: We, as a Society, recommend the

26 basis for fees; but nobody has set a fee as such.

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28 THE CHAIRMAN: Are there any further questions?

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30 Do you have any further comments, Mr. Clark?



1 MR. CLARK: I would like to thank the Enquiry
2 for hearing us, Dr. Hagey. Although we are a small Society,
3 I feel that through the efforts of our practitioners, we are
4 rendering a service to quite a number of people, far greater
5 than the number of physiotherapists, and I feel that we would
6 have been remiss if we had not made representations to the
7 Enquiry and I thank them for their generosity in hearing us
8 out.

9 THE CHAIRMAN: We are very pleased to have
10 heard you.

11 I would like to meet with the members of the
12 Enquiry privately for just a few moments, if you would stay.

13
14 --- Adjournment.

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1 A STAFF MEMBER MR. CLARK: I would like to thank the Endury
2 for hearing us, Dr. Haggy. Although we are a small Society,
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4 rendering a service to quite a number of people, far greater
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6 have been remiss if we had not made representations to the
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9 the number. THE CHAIRMAN: We are very pleased to have
10 heard you, and to encourage them with the inclusion in this
11 Bill. I would like to meet with the members of the
12 Endury privately for just a few moments, if you would stay.
13 Then does your presence as a representative of the
14 Government?
15 MR. CLARK: Yes, but I am not a member of the
16 Endury in this Bill or body. I am a member of the
17 MR. CLARK: Yes.
18 MR. CLARK: Thank you.
19 THE CHAIRMAN: Are there any further questions?
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